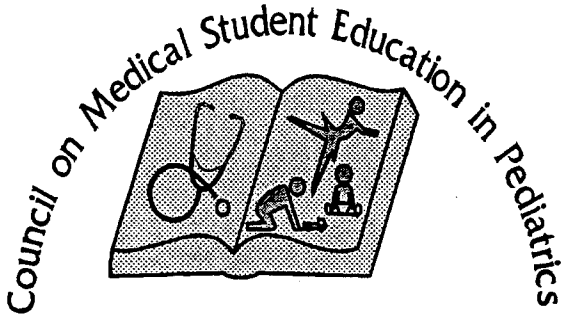
The Pediatric Educator



Volume 8 Issue 2 **Summer 2001**

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

Comments from our President, Richard Sarkin

President's Column

Greetings from Western New York! I want to thank all of you who made the 2001 COMSEP meeting in San Diego such a smashing success. The meeting evaluations were excellent with an overall rating for the meeting of 4.7 (scale of 1-5, 5=highest). The feedback from the Chairs has also been very positive. Special thanks to Nan Kaufman for hosting yet another combined AMSPDC/ COMSEP meeting. In addition to a myriad of other things, Nan arranged a beautiful LaJolla sunset over the Pacific Ocean followed by full moon for our Saturday night social event, not to mention delicious food and wonderful music.

One of the San Diego meeting highlights was a special award presented to Larrie Greenberg. Larrie was a founding member of COMSEP and served as the pediatric clerkship director at the Children's National Medical Center in Washington, DC, for 21 years. Larrie is now doing faculty development at George Washington and working as a consultant in medical education. He was presented with a plaque that read, "COMSEP honors Larrie W. Greenberg, MD, for his leadership, inspiration, humor and wisdom, his unwavering commitment to excellence, his outstanding contributions to scholarship in medical education, and his tireless dedication to learners and colleagues." Standing O! Congratulations, Larrie!

Plans are well underway for the 2002 meeting at the Hilton Suites in Nashville from March 14-17, 2002. Bob Janco and Joe Gigante from Vanderbilt and John Estrada from Meharry are jointly hosting this meeting. The theme for one morning of the meeting will be "Teaching Culturally Sensitive Care." In addition, using technology in medical education will be strongly emphasized throughout the meeting.

Other highlights include a plenary session by Joselyn Elders and a dinner social event at the Frist Center for the Arts featuring the Jubilee Singers. Please start thinking about workshops, research presentations and innovations in education that you might submit for presentation at the 2002 meeting.

For those of you who plan well in advance, enter Denver in your PDA's as the site of the 2003 COMSEP meeting. As of this time, we will gather at the lovely Omni/Interlocken Resort in Broomfield, CO, about 25 miles from the Denver Airport. Many thanks to Robin Deterding for her willingness to host the 2003 meeting.

I am delighted to report that the AMSPDC Executive Committee approved the budget for the new COMSEP web site. A COMSEP Web Site Advisory Group is now working with a commercial web site designer to implement an overhauled, state-of-the-art web site for our organization. Many thanks once again to Jim Harper from Nebraska for all of his efforts related to our web site that is still up and running at www.comsep.org.

The revisions of the COMSEP General Pediatric Clerkship Curriculum are now nearly complete. The final revisions are being edited and should be ready by 2002 in Nashville. The COMSEP mentoring program coordinated by Steve Miller from Columbia and Bill Wilson from Virginia has been highly successful. New COMSEP members have been linked with more experienced members for advice, resources and support. Any COMSEP member who would like to either serve as a mentor or be mentored should contact Steve (szm1@columbia.edu).

We have just begun several collaborative projects with the Association of Pediatric Program Directors (APPD). Bruce Morgenstern from Mayo, Stuart Slavin from UCLA, Tim Kelly from UCSF and Bob Englander from Maryland are coordinating these efforts. We met during the PAS meeting in Baltimore with Carol Carraccio, the President of the APPD, and Ed Zalneraitis, the president-elect of the APPD, to discuss our organizations' mutual interests. One joint project relates to letters of recommendation written for students applying to pediatric residencies by faculty and Chairs. Another joint project deals with advice for medical students choosing careers in Pediatrics. This summer, all incoming PL-1's in pediatric residencies or combined pediatric residencies will be asked to complete a COMSEP/APPD survey. This survey will allow us to better understand PL-1's experiences with the advice they received in medical school and with their match in Pediatrics. I am excited about this new opportunity to work collaboratively with the APPD.

Congratulations to the COMSEP Research Task Force team headed by Nick Jospe for their recent publication dealing with an assessment of medical students' interest in a career in pediatrics following their pediatric clerkship (Jospe N, Kaplowitz PB, McCurdy FA, Gottlieb RP, Harris MA, Boyle R. Third-Year Medical Student Survey of Office Preceptorships During the Pediatric Clerkship. *Archives of Pediatrics & Adolescent Medicine* 2001;155:592-596).

Please watch for the article about COMSEP that I was asked to submit to the *Journal of Pediatrics*. The article was accepted for publication and will be published sometime in the next few months.

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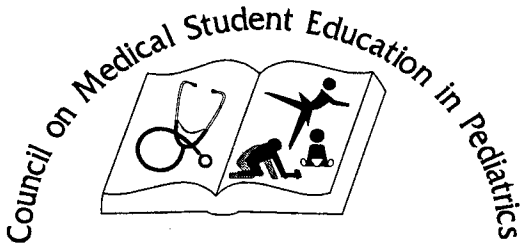

UNDER THE AUSPICES OF THE
Association of Medical School Pediatric Department Chairs, Inc.

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COMSEP ANNUAL MEETING
UPCOMING DATES

2002
Nashville, Tennessee
March 14-17, 2002

2003
Broomfield (Denver), Colorado
April 2-7, 2003

2004
Panama City, Florida
March 3-8, 2004
AMSPDC/COMSEP COMBINED MEETING

Have a great summer! Please contact me with any suggestions, comments or questions. I look forward to seeing you in Nashville.

Richard Sarkin, M.D.
President, COMSEP
SUNY/Buffalo

COMSEP 2002 MEETING
March 14 – 17
Nashville, TN

Meharry Medical College School of Medicine and Vanderbilt University Medical Center will be hosting the 2002 meeting of the Council on Medical Students Education in Pediatrics (COMSEP). The meeting will take place at the Hilton Hotel located in downtown Nashville. The Meharry-Vanderbilt Alliance, a not-for-profit organization representing both hosting medical centers, has offered to co-sponsor the meeting. At the 2001 COMSEP meeting in San Diego, the hosting institutions proposed "Teaching Culturally Sensitive Care" as the theme 2002 meeting. This idea was well received by both the COMSEP Executive Committee and the general membership. The hosting institutions have challenged each of the COMSEP task forces to devote a considerable portion of the annual meeting to the issues of cultural diversity and cultural sensitivity. Meharry and Vanderbilt universities offer individual characteristics that, coupled with the interest and experiences on cultural issues nationwide, will make for a successful meeting dedicated to preparing medical students to practice medicine in increasingly culturally diverse environments.

Meharry Medical College, the oldest independent historically black medical school, has graduated 15% of all practicing black physicians and dentists in the U.S. Its faculty staffs the Metropolitan Nashville General Hospital that primarily serves Blacks, Hispanics and other minority and inner city patients. Vanderbilt University Medical Center is a research intensive, tertiary care medical center cited by *U.S News and World Report* as one of the top 20 medical centers in the U.S. The two medical centers are closely located in Nashville, Tennessee, and have had a long history of collaboration primarily in the field of research. The formal one-year-old Meharry-Vanderbilt Alliance currently facilitates joint projects in research, training and patient care. Bringing together the individual and different missions of these institutions has been the major challenge for the Alliance. Our colleagues at both institutions believe that model enterprises such as this, which successfully take advantage of culturally diverse environments to train medical students, offer lessons that can be shared at the 2002 COMSEP meeting.

A combination of plenary sessions, workshops and poster presentations comprise the format for COMSEP annual meetings. The following speakers are being considered for plenary sessions: 1) Jocelyn Elders, M.D. speaking on culturally sensitive care (confirmed), 2) Albert Gore (to be confirmed) speaking on empowering minority communities, and 3) Clifton Meador, M.D. (confirmed) for the plenary session on the experiences and goals of the Meharry-Vanderbilt Alliance. As for workshops, a list of potential topics was developed at the 2001 COMSEP meeting in San Diego, to guide members into designing workshops related to teaching culturally sensitive. This list, along with guidelines and tips to develop workshops will soon be posted at the COMSEP Website

PREPARED BY: John

Estrada, M.D. (Meharry), Joseph Gigante, M.D. (Vanderbilt),Bob Janco, M.D. (Vanderbilt), and Nanette Bahlinger (CME office at Vanderbilt),

Welcome!
In preparation for our annual meeting in 2002 in Nashville, we've just completed the Grand Slam of Culture with three new venues opening this summer. First to open was the Frist Center for the Visual Arts. Housed in a classic art deco style post office built in the 30's, the Frist Center will be the location of our cocktail hour and dinner. It is within walking distance of our hotel, the Hilton Suites Downtown. Our entertainment will be the world-famous Jubilee Singers from Fisk University in Nashville.

Second event of the Slam was the new Country Music Hall of Fame. Situated across the street from our hotel, this interactive museum displays important artifacts documenting milestones in the origin, evolution, and legacy of country music. Bluegrass, honky-tonk, Western, R&B, rock 'n roll, folk, and modern country share the exhibits. Key to the concept of the Hall of Fame will be to document the major role of songwriters and session musicians in this musical genre. And yes, Elvis' Cadillac, or one of them, will be there; he will not be in the building however. Anyone heard of Boudreaux Bryant?

Third to open will be the Nashville Public Library. A joint public and private venture, this neo-classical structure will provide state-of-the-art access to resource services using all sorts of computer assistance. The Library's grand design features mahogany shelves, rich marble detailing, plush reading rooms, and splashes of natural light. The design emphasizes open access for students K-12 with interactive projects that make it a living library instead of a collection of works by dead authors. Live music will be featured as well. A cafe will serve coffee, lunches and delicacies from Provence. No corn dogs or chicken wings allowed! The library is 3 blocks from our hotel.

Hungry for food or music? The restaurant scene downtown is expanding with loads of good places within walking distance. A short cab ride can take you to many other neighborhood or specialty gourmet restaurants. We will organize dance lessons at the WildHorse Saloon for those hardy people who insist. Several live music clubs offer jazz, honky-tonk, rock, traditional country, bluegrass, and even hip-hop--whatever that is.

Thirsty for blood or music? Additional events include NHL hockey and the Grand Ole Opry--both are a half-block from the hotel. Tickets to the former should be available unless the Red Wings are in town. Tickets to the latter are sometimes scarce so check with your concierge on arrival. The Opry has 2 shows on Friday and Saturday evening.

So you see, there will be more than enough to fill your dance card while you are here. Our Tourist Bureau would be happy for you to stay longer.
Indeed, there are lots more to do if you want to take in historic Civil War battlefields; some say the Battle of Nashville was the turning point of the Western Campaign heralding the end of the Confederacy. We also have President Jackson's estate, the Hermitage, Belle Meade Mansion, home of the stud that sired the line of modern thoroughbreds, Cheekwood Mansion, Percy

Warner Park, and the Van Vechten Gallery with its incredible collection of Georgia O'Keefe and Alfred Steiglitz. Oh yes, Vanderbilt University houses my 8 by 10 ft office with modular plastic furniture and a view overlooking middle Tennessee's largest parking garage. Tours can be arranged.

See y'all.
Bob Janco (known to friends as Billy Bob)

The following reports are updates of meetings pertinent to COMSEP members.

UME-21

The third annual meeting of the **UME-21 project** was held in Washington, DC on March 16-17. I attended as the representative on COMSEP on the Advisory Board. As many of you know, UME-21 is a HRSA sponsored project providing grants to 18 medical school, 8 of who are the Partner Schools, to develop curricula and strategies to better prepare physicians to practice medicine in an increasingly managed care environment. Each medical school is working in partnership with a community health care delivery system. The idea is to come up with strategies that meets the needs of the practice environments where our students will eventually practice medicine.

The meeting began with presentations from each of the Partner Schools on the successes and difficulties they had encountered. Some of the things I took away from the meeting are:

1. Managed care has become a "dirty word", not to be used in public. Although the projects originally seemed to be designed to prepare students to practice in the managed care environment, that term was clearly avoided. It was brought out that managed care has not only been vilified by the press and the public, but it has not been the solution to rising health care costs that people had hoped.

2. Evidence-based medicine is another term that is falling out of favor. Instead, terms like critical thinking, clinical effectiveness and clinical decision making were used.

3. When introducing targeted topics like ethics, prevention, cultural awareness and health systems finance, it is better to use experts to weave the topics into each clerkship rather than pull the students out for isolated presentations.

4. When talking about making changes in medical school curricula, one of the best quotes was "Sacred cows make the best hamburgers"!

The remainder of the program consisted of plenary presentation, small group discussions and workshops. Speakers included Nicole Lurie, the former Deputy Assistant Secretary for Health and Sam Shekar, the Director of the Bureau of Health Professions. Sam Shekar pointed out the need for increased cultural competency among medical practitioners and need to prepare physicians for the tremendous impact of new knowledge in genetics and the aging population. The most interesting talk for me was the presentation by Walter Talamonti, the Medical Director for Ford Motor Company. He talked about the impact of the enormous increases in health care costs for their employees, dependents and retirees, mentioning the cost of prescription drugs, the effect of advertising on use and prescribing practices of physicians. In a nutshell, if

we cannot reign in the costs of providing health care, Ford Motor Company will go out of business in the US. Managed care has not helped lower health care costs as expected.

UME-21 project members and others, including some COMSEP members made small group presentations.

Some things to keep in mind for the future:

1.The UME-21 goals may be linked to medical school accreditation to force medical school to take them seriously.

2. Plans are being made for a very big symposium on medical education to be targeted to a broad audience to take place at the end of the UME-21 project, perhaps in the fall of 2002.

3. There was discussion about a future HRSA project similar to UME-21, perhaps targeting quality health care and patient safety. It would be inter-disciplinary and address cultural issues, disparities and populations. It is estimated to be a $7-8 million project and perhaps be linked to Healthy People 2010.

Nan Kaufman
U.C. San Diego

ACE REPORT

ACE, the Alliance for Clinical Education, is the organization of clerkship director organizations (somehow seems repetitious). The COMSEP representatives are Nan Kaufman and Bruce Morgenstern. Fred McCurdy is ACE president. ACE is the group that put together the Clerkship Directors Manual that each school's primary clerkship director should have received. ACE has also been the group that secured the opportunity to have material from the meetings of the individual member organizations (such as COMSEP) published in the journal Teaching and Learning in Medicine. The abstracts from COMSEP will be published in an upcoming edition of the journal.

ACE has two ongoing major initiatives: strategic planning to reassess its mission, vision and goals. This also includes discussions that examine the role of ACE with other educational groups, such as the AAMC. COMSEP will have the opportunity to have input into the final version in the next few months. Finally ACE is working on a position statement or white paper that reviews the role of the clerkship director, and addresses the resources the CD will need to do the job properly. In these strained economic times, it is clear that we will need to advocate for ourselves. Bruce Morgenstern is on the workgroup drafting the original document, which will be open for comments from the member organizations by August (we hope).

Bruce Morgenstern
Mayo Medical School

APA SIG Review: Medical Student Education

Focus (2000-2001): Competency Based Evaluation

The Medical Student Education SIG is dedicated to being a home for all people who are interested in medical education. As such, its' activities are relevant to a wide variety of people. Education, and its close cousin, effective communication are critical areas for those who identify with:

- Faculty Development

- Injury Prevention
- Emergency Medicine
- Residency Training
- Continuity Clinic
- Informatics

to name a representative few.

This year's work concentrated on "Competencies". 84 people signed in, and over 100 people participated in the SIG.

SIG Goals:
The goals of the SIG were and are to:

1) Identify and influence the agenda of medical education and
2) To provide a home base for anyone who sees medical education as critical.

Our unique charge is to enlighten the education community in education, through the eyes of the student.

The agenda that we chose to focus on is competencies – and its effect on medical education and training. We reviewed the critical components of a competency-based approach and, through spirited facilitated discussion and work, we identified the following key points and challenges.

Key Points about Competency Based Evaluation

1) We must develop frameworks, which facilitate direct observation of our students and residents.
2) We must develop non-labor intensive evaluation methods, which can be widely distributed, in order to test competence in basic universal skills.
3) We must develop a common language to describe the essential competencies.
4) We must explicitly define the boundaries of service and education in a way that allows for learning while doing.

We also produced an essential review of the literature on competency-based evaluation and a document outlining the key features of a competency based approach.

Agenda for 2001-2002

This set the agenda for the coming year around a number of possibilities. These are:

1. Competency Based Evaluation: Apply to professionalism/Advocacy/ Common scenarios/ Communication Skills

Or

2. Bedside Learning/Feedback/ Evaluation – A Critical tool for Competency based Evaluation

Or

3. Applications of Technology (for evaluation)

Or

4. Communication/Patient education

We will decide on our direction, via work on the email list – with a deadline of June 7th 2001. The core-working group of last year was identified and this year's group was thanked.

APA Medical Student Education:
Working Group: 2000 – 2001
Steve Miller, MD (Chair)
Bill Raszka, MD
Lindsey Lane, MD
Rani Gereige, MD
Maria Marquez, MD
Nicolas Jospe, MD
Jon Fleigel, MD
Mike Barone, MD

Guests: Medical Students from Johns Hopkins and Georgetown (under direction of Mike Barone/Maria Marquez.

Senior educators attended the

meeting including, Larrie Greenberg, Rich Sarkin, Ben Seigel, Karen Marcdante, Bruce Morgenstern, Ardis Olson, Mike Lawless, Nan Kaufman, Paula Algranati, Henry Schaeffer, Jerry Woodhead and others. About 25% of attendees were new members. We will continue to publicize the SIG to possible non-APA members with associated interests. (APPD members/Patient Communication experts/Others)

Submitted by Steve Miller, MD, Columbia Univ.

AAP Committee on Pediatric Education

Patricia Kokotailo is the COMSEP representative to the American Academy of Pediatrics Committee on Education and our liaison to the AAP. The Committee met last on July 16-17, 2000 and included updates of the major pediatric societies and organizations efforts in pediatric education as well as updates on AAP educational programs. The main focus of the meeting was the review of the AAP Future of Pediatric Education (FOPE) II Task Force Report, published as a supplement to the 1-00 issue of *Pediatrics*, and the start of establishing a process to implement the recommendations. It was proposed that an advisory committee would be established through the Federation of Pediatric Organizations (FOPO) and an executive director be hired. COMSEP is not a member of FOPO, but is represented through AMSPDC, our parent organization. It will be especially important that COMSEP have input into curricular and medical student education issues in this implementation process. Throughout these discussions, the COMSEP General Pediatric Clerkship Curriculum and Resource Manual was cited as an excellent standard for the development of measurement of competency in medical student education. Further update on this process will be forthcoming after the next COPE meeting on 7/22-23/01.

COMSEP continues to work with the AAP on a number of medical student education issues. Medical student membership in the AAP is currently under the Resident Section, and there are over 500 student members currently enrolled. Pat Kokotailo and Ken Slaw, the AAP Director of Member, State, and Chapter Affairs met with the AAP Membership Committee on 10-7-00 and proposed a lowering of student membership dues from the current $30.00 per year, and solicited ideas for community preceptor recognition from the AAP from this committee. There was good support for these issues and the dues lowering recommendation will now be taken back to the AAP board. After presentation of this information at the 2001 COMSEP meeting, Pat Kokotailo will now take back additional suggestions of preceptor recognition by the AAP including national plaques or certificates and discounts on AAP dues and publications for community preceptors to the AAP. Ken Slaw also participated in the development of two workshops at the 2001 COMSEP meeting, "Creating Pediatricians: Implementing Mentorship for Medical Students" and "Before and Beyond the Clerkship: Opportunities and Challenges in Promoting Pediatrics".

Submitted By Patricia Kokotailo, Univ. of Wisconsin

Millennium Conference on the Clinical Education of Medical Students

In April 2001 representatives from 11 U.S. medical schools met in

Boston over three days to participate in the Millennium Conference on the Clinical Education of Medical Students. The meeting, jointly sponsored by the Carl J. Shapiro Institute for Education and Research at Harvard Medical School and Beth Israel Deaconess Medical Center and the AAMC, was conceived to foster a collaborative effort among sister institutions to develop innovative approaches to clinical education in the twenty-first century. The goals of the conference were to develop strategies for improving the quality of the clinical education of medical students that could guide participants in their efforts to implement changes in the clinical curricula of their schools.

Institutional teams, which consisted of educational leaders at the medical school, clerkship, and residency levels, were selected from over 40 applicants to represent the spectrum of members of the AAMC. Schools that participated included Baylor, UCLA, University of California San Francisco, Duke University, Uniformed Services University of Health Sciences, Harvard University, University of Iowa, Mayo Medical School, MCP Hahnemann University, Mount Sinai, and the University of Rochester. COMSEP members who attended the conference with their institutional teams included Jennifer Koestler, Helen Loeser, Stuart Slavkin, and Robert Swantz.

Jordan Cohen, MD, President of the AAMC was the keynote speaker who charged the group with developing "disruptive innovations" in medical education, that are not merely evolutionary, but revolutionary in nature. Kenneth Ludmerer, MD, author of Time to Heal, received the first Daniel C. Tosteson Award for Leadership in Medical Education.

The conference was organized to build on the work of the AAMC's Medical School Objective's Project (MSOP) and the follow-up studies in their Project on the Clinical Education of Medical Students. The agenda for the conference focused on three key questions: What do we teach – Evolution of the optimal curriculum; How do we teach – Logistics of optimal delivery of the curriculum; and Who teaches – Issues re: selection of faculty, faculty development, and support. The format of the conference was highly conducive to discussion and interaction, with small breakout group discussion (inter-institutional membership) guided by plenary sessions. The conference concluded with deliberations by each school team and reports of their individualized plans for implementation. The proceedings of the conference are due to be published later this summer.

Submitted by Robert Swantz
Univ. of Rochester

The following articles are reports of the Task Forces that meet at the last COMSEP Meeting in San Diego.

Curriculum Task Force meetings at COMSEP 3/10 and 3/12/01

Both meetings were well attended.

First Task Force meeting 3/10

This meeting was devoted to discussion of *Curriculum* revision and to the Computer-assisted Learning In Pediatrics Project (CLIPP).

Curriculum: We first discussed progress towards revision of the *Curriculum*. The revision process has been underway since the 2000 COMSEP meeting. Over the

past year, individual members took responsibility to review and revise specific sections of the *Curriculum*, typically working with a group of COMSEP members. Jane Curtis and Jerry Woodhead collected these revisions. In January of this year a group met in Winston-Salem North Carolina at Bowman Gray Medical School (hosted by Mike Lawless). The group included Nan Kaufman, Lynn Manfred, Michael Giuliano, Cindy Christian, Mike Lawless, and Jerry Woodhead. The group review process was very helpful, but took much longer than anticipated – we completed review only of the sections devoted to Skills, Adolescence, Newborn and Genetics. Time did not allow review of the remaining sections, so a decision was made to use some time at the COMSEP meeting for this purpose.

At the COMSEP meeting a group met on Friday March 9 and completed the review of the sections devoted to Common Illnesses, Health Supervision, Growth, Development, and Prevention. This left 6 sections remaining for review. The decision was made to spend time at the second Task Force meeting to complete the review of these remaining segments.

CLIPP: The second half of the Task Force meeting on March 10 was devoted to a presentation about the Computer-assisted Learning in Pediatrics Project (CLIPP) by Leslie Fall. This web-based educational project will provide 31 cases based on the *APA/COMSEP General Pediatrics Clerkship Curriculum*. COMSEP members have demonstrated great enthusiasm for the project, which is proceeding at steady pace.

Second Task Force meeting 3/12

On Monday March 12 the meeting was held jointly with the Evaluation Task Force. Roger Berkow will summarize the Evaluation portion of the meeting in a separate report.

The Curriculum portion of Monday's meeting was devoted to group reviews of the remaining sections: Advocacy, Chronic Illness, Fluids & Electrolytes, Nutrition, Emergencies and Poisoning. The review involved many COMSEP members who had not previously been involved with *Curriculum* revision. Three separate groups of 10 – 12 members worked on these sections and achieved consensus about recommended modifications to the current document. This activity demonstrated the enthusiasm with which COMSEP members approach the *Curriculum* and their strong sense of ownership of this key educational tool. The only section remaining to be revised is Therapeutics – which needs to be linked with the Common Illness section.

The next step for revision will be to collate all of the revised sections and have them reviewed by an education expert to ensure that objectives and competencies have the appropriate format. The collated sections will also be distributed to the working group for their comments. A meeting of the working group will be scheduled for late summer or early fall for a final group review of the *Curriculum*.

Issues for the future

Leadership: I assumed leadership of the task force from Ardis Olson in 1997. I believe that it is time for new ideas and energy in the leadership position. At the COMSEP meeting I met with Richard Sarkin to discuss a transition to new co-chairs for the task force. Since that meeting, Bill Raszka and Nan Kaufman have agreed to work with me over the coming year to finalize the

Curriculum revision, and then to assume the joint leadership of the Task Force at the annual COMSEP meeting in Nashville in March 2002.

Ongoing projects for the Task Force: The Task force will continue to work on the further evolution of the *Curriculum*, and, in particular, may wish to address several issues:

1. The recommendations made in the Medical School Objectives Project (MSOP) of the AAMC: (See http://www.aamc.org/meded/msop/start.htm). While the majority of the MSOP objectives for general issues are well addressed by the *Curriculum*, specific issues related to technology and medical informatics are not.

2. The new guidelines from the ACGME for the development of competency-based education and evaluation programs in residency training will have an impact on medical student education. The COMSEP Curriculum Task Force will undoubtedly wish to review the Curriculum in light of the ACGME guidelines. (See http://www.acgme.org/index.htm). Competency-based evaluation was the topic of the Special Interest Group on Medical Education at the APA meeting in Baltimore (to be discussed by Steve Miller in a separate report).

3. Revision of the *Resource Manual* that accompanied the first edition of the *Curriculum*: Much has changed in medical education since this resource manual was developed. A revision would require a major commitment by the Task Force and by COMSEP as an organization. Does the *Clerkship Director's Handbook* that was developed by the Alliance for Clinical Education (ACE) and made available by AAMC replace the COMSEP *Resource Manual*, or does COMSEP need to review both documents and revise portions of the *Resource Manual*?

This could be a discussion point at the Nashville meeting.

Evaluation task force – Report

The evaluation task force met twice at the annual COMSEP meeting in San Diego. During the first meeting the topic of discussion revolved around the concepts of Competency based evaluation. This was in partial preparation for the APA-SIG on education that was held at the annual PAS meeting in Baltimore. The discussion focused on the amount of labor that is required for adequate assessment of competencies, and how best to undertake such an assessment. The group brought up the established was of evaluating competencies, such as direct observation, OSCE, computer-based evaluation and videotape of student interaction. The group ended a lively discussion of this topic with no clear conclusion, except to continue the discussion in Baltimore. The second meeting of the evaluation task force was in combination with the curriculum task force. In this forum we participated in working on the revision of several sections of the

curriculum.

Respectfully submitted by
Roger L. Berkow

Faculty Development Task Force

The Faculty Development Task Force met on March 10 and 12 at the 2001 COMSEP meeting in San Diego. We reviewed the projects discussed at last year's meeting, as well as ongoing projects and plans for future activities and next year's meeting. As is the tradition of this group, there was active and enthusiastic discussion, and many ideas were offered.

Journal Review: Steve Miller was acknowledged for his role in organizing and coordinating the journal review activity, with annotated reviews published in the Pediatric Educator. Volunteers for the upcoming year were solicited, and will be contacted by Steve.

Workshop "Pairing". The idea to "pair" workshop presenters, which initiated in this task force, has been highly successful. There was discussion regarding further enhancements, including striving for "multi-institutional" pairing and trying to pair more senior members with newer COMSEP members in designing and presenting workshops.

Mentoring Project: The Mentoring Project was discussed; it seemed to be going smoothly at this year's meeting, and several members commented on the "First Timer" tags as being useful in identifying new members. Several suggestions were offered for improving this process, including starting earlier with contacts to new clerkship directors (well before the annual meeting). Renee Moore, Steve Miller, and Bill Wilson will work on this project.

"Meet the Experts" Lunch: The plans for the lunch session were reviewed before the luncheon, with discussion of the sessions at the Sunday meeting. The lunch session went smoothly, and should be continued at future meetings.

Recurring Workshops: At last year's meeting, the idea of having a group of core workshop topics that should be presented regularly was endorsed. Several of these topics were covered on the workshop program for this year, and it was felt that "core" workshops should be a part of each year's program. Topics suggested as "core" topics included workshops (how to plan and conduct a workshop), promotion portfolio development, the problem learner, evaluation, feedback, curriculum development, teaching methods, problem faculty, and leadership. Janet Fischel reported on the "New Clerkship Directors" pre-conference workshop, which included several mini-workshops. It was felt that this should be an annual workshop. The possibility of a professionalism or leadership workshop for a future meeting was also discussed. This could have value to our membership, particularly those who are moving into senior administrative positions at their home institutions.

Workshop topics: We discussed a number of potential topics for workshops at next year's meeting. Several topics were suggested, including informatics, teaching concepts of evidence-based medicine, use of hand-held devices, on-line testing, working with multimedia, teaching about alternative medicine, publishing and grant-writing for career educators, mentoring (students and colleagues), the

problem learner, "doctoring" and cultural sensitivity, using interpreters in patient care, teaching the adolescent interview, women in medicine, gender-related issues, workshops, portfolio development, resources for cultural sensitivity, developing and supporting community preceptors, off-site clerkship directors, professionalism, and the medical team and cultural sensitivity. Next year's meeting (in Nashville) will have teaching cultural sensitivity as a major theme, and the organizers have suggested some workshop topics in keeping with that theme.

New COMSEP website: We discussed ways in which the Faculty Development Task Force could use the new website for faculty development and for providing resources for Pediatric education. Dr. Stephen Blatt volunteered to serve as our liaison with the Technology Committee. Some of the material that might be considered would be an annotated bibliography, annotated links to other websites relevant to medical education and faculty development, as well as presentations and synopses of workshops that might be adapted to the web.

Suggestions for workshop improvement: There was discussion about the occasional problem of workshop descriptions not matching the eventual content, as well as ways to identify the target audience for workshops.
A committee was formed to improve the guidelines for submission and expectations. There was discussion of ways to get feedback to the workshop presenters. One suggestion was the development of feedback forms, to be generated by each workshop-presenting team using a template that could be posted on the website and then customized. These forms could be completed and returned to the workshop presenters at the end of each workshop and would be for internal use by the presenters. The possibility of utilizing some of the more experienced members of COMSEP in evaluating workshops and providing constructive feedback was also discussed.

We anticipate a busy year as we prepare for next year's program in Nashville, and welcome participation from all COMSEP members.

Submitted by

William G. Wilson, MD
Steven Z. Miller, MD

Learning Technology Task Force (LTTF) – 2001

The LTTF meet on March 10th. Members were then asked to participate in other task forces on March 12th to link technology with the other working areas. The following information incorporates information related to the LTTF that occurred through out the COMSEP meeting and not just in the task force meeting.
Members in attendance at the March 10th LTTF meeting:

Maureen Rickerhauser M.D.; mrick@home.com
nasreen talib MD; ntalib@cmh.edu
carol edwards (not an MD); carol.edwards@dartmouth.edu
Ted Sectish, MD; theodore.sectish@medcenter.stanford.edu
Pradip D. Patel MD; PDPATE01@gwise.louisville.edu
Kathleen Previll; previllk@mail.ecu.edu
Stephen D. Smith; ssmith8@kumc.edu
Robert Drucker; robert.drucker@duke.edu
David A. Levine; levined@msm.edu
Mark Hormann; mark.d.hormann@uth.tmc.edu

David Warren;
dwarren@uwo.ca
Chris White;
cwhite@mail.mcg.edu
John VanderMeulen;
vmeulen@mcmaster.ca
dbrandon@creighton.edU
norman.b.berman@hitchcock.org
Phillip H. Kaleida, MD;
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Jared Caruso ;
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Bruce Morgenstern ;
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Pat Patterson;
pattep@mmc.org
Sajjad Yacoob;
syacoob@chla.usc.edu
Hammond J. Dugan;
hjdskr@erols.com
Vijjeswarapu Daniel ;
vijjesd@driscollchildrens.org
Jo-Ann Harris;
jsharris@bu.edu
Adam L. Hartman;
adamlhartman@yahoo.com
Michael Dell;
msd3@po.cwru.edu
Robin Deterding;
deterding.robin@tchden.org

LTTF Issues:

I. The Website was discussed as approval for funding has been achieved. LTTF members were excited about the possibilities.

We discussed the need for a web editorial board and a web master.

A. Web editors: All those interested were asked to talk to Robin Deterding or Bruce Morgenstern. Based up the response to this request the following committee will be assembled:

1.Robin Deterding;
deterding.robin@tchden.org
2.Bruce Morgenstern;
bmorgenstern@mayo.edu
3.Chris White:
cwhite@mail.mcg.edu
4.Norm Berman:
norman.b.berman@hitchcock.org
5.Chris Maloney:
chris.maloney@hsc.utah.edu
6.Jim Harper:
JLHARPER@UNMC.EDU
7.Bill Raska:
wraszka@salus.med.uvm.edu
8.Jo-Ann Harris:
jsharris@bu.edu
9.Bob Wittler:
rwittler@kumc.edu

B. Web master: All those interested were asked to talk to Robin Deterding or Bruce Morgenstern. No one expressed an interest. We expect someone will emerge from the web editorial board once people have a better understanding of the duties.

C. All LTTF members need to understand the different web features that can be possible for the COMSEP website. We will be asking for your input very soon! Please review the following sites:

1. www.infostreet.com will be the company that will be hosting the site though we need to get a contract together. Please review this site.
2. www.asco.org is a site developed by infostreet. Please review the features.
3. Other organizations can also be found on the infostreet site to review.

II. Clipp: Please talk to Norm Berman or Leslie Fall if you are interested in:

1. Authoring cases
2. Peer reviewing cases
3. To see a current case - Check out:

http://casus.medinn.med.uni-muenchen.de/cases_ english.

html
Login – vsd
Password – vsd0

III. Medical informatics was discussed in relationship to what different organizations think medical student should know. Members may not understand many of these items. Faculty development initiatives need to be done to address these issues. Resources that were mentioned as references include the AAMC Clerkship Directors Manual and the MSOP Objectives. We could use electronic links to this material if available.

IV. Workshop Ideas for up-coming meetings

1. MSOP informatic: Basic issues. (Jo-Ann Harris will consider putting together a workshop for next year.)
2. Evidence Based (EMB)
3. Personal Digital Assistants (PDR). We think this will continue to be an important area and see this as a workshop in the future.
    a. How to use in education
    b. How to use clinically
    c. How to teach to students
    d. Patient log trackers
4. Vendor exhibit: Hardware / software: We will work with Nashville to see if this can happen. Bruce Morgenstern will look into this.
5. Tech demonstrations – Most felt that more demonstrations from other people should be included and perhaps shown with the vendors? Most people what to see these but putting them in just a workshop limits exposure. We need to work with Nashville to plan. Maybe the demonstrations can be with the posters and maybe for a longer period?
6. Tutorials: Web – based (for example: prerequisites of web based learning). Steve Miller wants to put up some of his work on feedback by the end of the year. We expect this area to grow as the website matures.
7. On-line Evaluation of students, faculty, clerkship (vendors with software?)
8. Production of multimedia (the I-movie pre-conference was well received and many thought it should be done again. A suggestion for PC editing was made but software is not as easy to use or at this time as cheap. Currently most graphic work is done on Macs.)
9. Use of the COMSEP website (plenary?). Teaching our members how to use the site and contribute to the site may be very important to increase our on-line community. All members felt this was important.

Members with specific committee interests:

Curriculum:
Jo Ann
Bob Drucker

Evaluation:
Robin Deterding
Chris White

Faculty Development:
Kathleen Previll

Submitted by Robin Deterding, Univ.of Colorado

Addendum as of 5/1/01:
The web editorial board has had one group conference call with Infostreet to discuss the COMSEP website options. Most members felt that the features could be very exciting for our organization. Currently web editorial members or exploring a COMSEP demonstration community put together by the company to help us with our understanding and vision.

Research Task Force

The Research Task Force met twice during the COMSEP meeting. We discussed our mission to promote individual and collaborative research projects and to develop a product of our task force each year. To that end, we have decided to submit a research task force workshop for next year. One idea that we had was a workshop on "How to navigate through your local IRB".

We also discussed an individual research project and gave feedback and suggestions. Our next order of business was evaluating the abstracts that were submitted to this years COMSEP meeting for submission to the new journal Teaching and Learning in Medicine. We evaluated these using a 5-point scale and classified them as whether they fell into innovations or research. We chose 9 of the 21 abstracts for submission. All members participated in the discussions and most returned the next day for a second session. We plan to make a email list of the participants and then plan a workshop for next year's meeting.

Submitted by Cindy Christy, Univ. of Rochester

Following the last COMSEP meeting, several first time attendees submitted the following comments about their experiences.

COMSEP First Timer

One day, my chairman (a former COMSEP member) told me that I should go to the annual COMSEP meeting every year, and that I should be actively involved with their work in the future. I did not understand what I was supposed to do, until I went to the San Diego meeting. It was an unimaginable experience. As a first timer, I was impressed with the friendliness of the team, and their dedication to education. Everyone's high energy is transformed into education. Furthermore, their concept of mentorship was incredible. All the members shared their expertise without hesitation, and that was unique. In my opinion the best thing was the exposure to wonderful ideas that inspire you to do better work when you return to your institution. As a "rookie", I thank you very much for allowing me to have a great time learning from you.

Submitted by Maria L. Marquez, Georgetown

New Attendee Comments

I was asked as a first time attendee of COMSEP to reflect on my experience at the meeting. As I have had time to reflect on the meeting (I did not write this immediately on return as suggested by Richard) my lasting impressions of the meeting are of cooperation and usefulness.

I was struck by the friendliness of the group to new members as well as the apparent camaraderie of the existing members. I feel very fortunate to be involved in a group that cooperatively and collectively is tackling one of the big medical education issues facing all of us: competency based education.

I'm certain I would never be able to complete this task on my own, but feel confident I will be able to comply with the LCME mandate by adapting the COMSEP competencies to address the student experience at Rush. It is nice to be involved in a group that has taken to heart "many hands make light work."

The other aspect I enjoyed about the meeting was how extremely practical and useful the workshops and the large general sessions were. I can

confidently say that I will be able to adapt and incorporate into my clerkship something I learned from each of my workshops: Lindsey Lane's structured clinical observations, palm pilot technology, feedback skills, and using Bill Raszka's MCQ computer technology to make teaching files. Having the opportunity to hear Dave Irby was a big WOW! I'm already looking forward to Nashville.

Submitted by Charlie Gaebler, Rush Medical School

Once again Steve Miller and his "recruits" have done an outstanding job reviewing the literature pertinent to COMSEP members.

Pediatric Educator Literature Review

Welcome to our sixth journal review. I'd like to acknowledge Karen Wendleberger Marcdante 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 listserve with your comments. (Steve Miller, MD)

Pediatric Educator Journal Review

Editors: Steve Miller, MD, Bruce Morgenstern, MD, Lindsay Lane, MD

1. Review: Communication's Core Elements in the Medical Setting. JEFischel, PhD, Dept of Pediatrics, University Medical Center at Stony Brook, Stony Brook, NY 11794-8111

Extensive work, fine insight, and the wisdom of experience are reflected in an essay in Academic Medicine (2001, 76, 390-393) entitled: Essential Elements of Communication in Medical Encounters:
The Kalamazoo Consensus Statement. Prepared by the participants in the May, 1999, Bayer Fetzer Conference on Physician-Patient Communication in Medical Education, the paper provides a succinct summary of core elements in doctor-patient communication. Heard this before? Perhaps, but not so clearly and succinctly. The essay refers the readers to five established models of doctor-patient communication, and transcends the details of any one of these in favor of a core of necessary ingredients for optimal communication skill. The core challenge in effective communication, the essay tells us, is building a relationship with a patient, recognizing three key factors: 1) the patient's illness with the illness experience for that person; 2) the fact that both patient and physician, through their views, values, and feelings, influence the dyad; and 3) the fact that relationship building is not focused and finished, but ongoing, across and within encounters. (In the scholarship of child

development, this would have close parallels to the transactional model of development.) The essay then provides a listing of essential communication elements in the segments of interview, from opening to closure. These are well articulated and lend themselves to adoption or adaptation for teaching.

The essay's strengths are clarity, coverage, focus, and generalizability to all specialties, and a spectrum of contexts of clinical care. Somewhat disappointing is the initial promise that this work will go the extra mile, with "tangible examples of skill competencies that would be useful for licensing bodies, organizations that accredit medical schools and residency programs, and directors of medical education programs at all levels (p. 390)." While behaviorally focused, the listed skills still require transition or translation, for example, into formats for curriculum, teaching strategies, and evaluation tools focused on the several competencies in essential communication skills. All in all, the essay provides a brief but insightful statement of a highly important core of skills in communication that is useful from the earliest days of training through the career span. It is a short essay and a useful read.

Janet Fischel
Dept of Pediatrics
University Medical Center at Stony Brook

(This is a terrific example of how a complex skill – such as effective communication – can be parsed into a limited number of essential tasks or competencies. Does anyone else have examples of other complex skills – which have been so well described – such as "being culturally competent"? Also – I believe we could incorporate these competencies into our COMSEP curriculum – Do you agree? How many of you teach effective communication – explicitly in the clerkship – and how many have an explicit model that you follow? (Steve Miller, MD)

2. Basco WT, Reigart JR: When do medical students identify career-influencing physician role models?. Academic Medicine 76:380-382, 2001

These authors surveyed one graduating class of the Medical University of South Carolina at graduation regarding a role model who had influenced their career choice (to choose the same specialty as the role model). Of the 62% of the class who responded, 23% had known their role model(s) before medical school, and 57% had met them in medical school. Of the group that met their role models in medical school, 65% did so before making their specialty choice. The mean time from beginning medical school to meeting these role models was 24.9 months. Students in a problem-based learning pathway met their role models earlier than those in the more traditional curriculum (11.6 months vs. 26.6 months).

This study illustrates the value of early exposure to faculty in the career choices of medical students. It was not clear from the paper if the students in the problem-based learning pathway were randomly assigned to this track or were self-selected; if there was self-selection, that might have influenced the outcomes. Schools who wish to increase the percentage of their graduates choosing primary care fields should develop strategies (such as compensation for teaching activities in the pre-clinical and clinical years) to encourage primary care faculty in their involvement with medical students.

William G. Wilson, MD
University of Virginia

(So, role models are important to career choice – do you all think it's the most important factor? What do you think are the top five? This is a good example of a fairly straightforward research methodology - a focused survey. (Steve Miler, MD)

3. Harding, SR and D'Eon MF. Using a Lego ™-based communications simulation to introduce medical students to patient-centered interviewing. *Teaching and Learning in Medicine* 2001; 13: 130-135

This article describes how to use an "analogous" game/role-play/simulation to teach the importance of patient-centered interviewing. A student pair role-plays the patient and the doctor. A shape made of 20 to 30 pieces of lego represents a patient history and is held, hidden, from the student who is role-playing the doctor by the student role-playing the patient. The doctor is given the same pieces of lego unassembled and has 7 minutes to ask questions and assemble his pieces into the "history". In the first simulation the patient may only answer questions with "yes", "no", "I don't know" or "I don't understand". This forces the doctor to use closed-ended questions. In the second simulation there are no restrictions on what the patient may answer.
The authors report that no student pair was able to complete the lego assembly/history using the closed-ended questioning style. Once the restrictions on answer type were lifted student pairs who adopted an open-ended, patient centered questioning style were able to assemble the lego history quickly. Students reported that the simulation made a contribution to their understanding of patient-centered interviewing. They felt more confident and reported their intention to use patient-centered interviewing in future. The simulation was well remembered half a year later.
Comment:
The authors did not look at whether this lego intervention improved student performance on real patient interviews. However, I think the key point here is that this was a memorable learning experience. This factor alone is likely to produce an impact on student behavior for a longer period of time than more traditional, and less memorable, teaching sessions. Here is another 'tool" for our teaching "toolbox" that I think is worth trying in small group teaching. I intend to pilot it and I'll let you know how it goes! Anything that helps drive home the message about how to communicate effectively with patients is worth the investment of time.

Lindsey Lane

(Does anyone else have any "creative" ways of making a teaching point – analogous to this one? The feedback "guess a number " game – comes to mind. How about having a COMSEP contest – for the most innovative – the prize? Well – a trip to Buffalo to accept congrats from Richard Sarkin - COMSEP president – (Steve Miller, MD.)

4. Howe A. Teaching in practice: a qualitative factor analysis of community-based teaching. Medical Education 2000;34:762-768.

The author sought in this qualitative analysis study of recently recruited English General Practitioners to determine key perceived facilitatory or hindering factors in the extension of community-based undergraduate medical education. Sheffield

University had developed a new multi-disciplinary module entitled "Medicine in the Community" which placed fourth year medical students in General Practitioner offices for eight-weeks. Each General Practice had one or two students for three days each week and the tutors at the practice were required to offer opportunistic clinical experiences, planned patient contact, and structured tutorial time. New tutors were recruited, supported by induction training sessions and written materials, and paid a stipend. All tutors during one academic year were asked to complete a written questionnaire at the end of each teaching block and 1/3 (N=15) underwent a semi-structured interview at the end of the year. Those interviewed were distributed among experienced and novice tutors, and both rural and urban, and large and small practices. Questions on both instruments revolved around issues of recruitment and retention; perceived impact and outcomes of their new teaching commitment; the course and the curriculum; training and support; and quality assurance. Influences were analyzed according to tutor, practice, and student factors using a framework approach.

Not surprisingly, factors that positively influenced the experience from the tutors view included previous experience, an interest in education, self-development, or practice type promotion, positive teaching experiences (mostly related to student involvement and enthusiasm), and a positive work environment. Increased pressure through longer consultation times was the most frequently mentioned difficulty for the practices. The author concludes that a multiplicity of factors play a role in tutor satisfaction. A motivated teacher with a good office team and an enthusiastic, responsive student creates and maintains a "cycle of satisfaction." Team disruption and student negativity interfere with maximal learning.

The limits of this study include the relatively small number of participants (and only those willing to take on a complex, extensive new commitment) and the somewhat different roles and attitudes toward General Practitioners in England and Primary Care physicians in the US. Nonetheless, this small study supports other reports of the positive and negative influences on community-based faculty. On both sides of the Atlantic, preceptors who value education, with good support teams, and enthusiastic students enjoy the experience while all worry about time and monetary constraints.

(These preceptors were paid to teach. How many of you have that luxury? Are you all still experiencing difficulty in recruitment of outpatient preceptors? The APA Community Scholars – may have some ideas on how to recruit and retain faculty. (Steve Miller, MD)

5. Val Wass, Roger Jones, Cees Van der Vleuten, . Standardized or real patients to test clinical competence? The long case revisited, Guy's, King's and St. Thomas School of Medicine, London, UK
Medical Education 2001;35:321-325

Psychometricians help us mortals establish the reliability and validity of our examinations. Sadly, little such psychometric analysis has been done on the long clinical case, using actual patients. As educators, we moved to OSCEs (shorter, scripted cases) to improve reliability, on the theory that more cases in any given time span will more reliably demonstrate students' global competence. [An individual case may be valid; for

example, a student may or may not perform pneumatic otoscopy properly at an OSCE station, but what does that single station say about overall competence?]

In this study, students had to undergo both a 20 station OSCE and 2 long cases, in which they had 14 minutes to obtain a clinical history and formulate ideas about the diagnosis and treatment. No physical examination was performed in the long case. An examiner (sometimes 2) observed the history, using a checklist, and the student then had 7 minutes to present the patient to the examiner. The examiner rated the presentation using global ratings.

The statistics, as one might expect from a psychometrics paper, are at once straightforward and complex. Generalizability coefficients, which measure reliability, were calculated. Two examiners in the long cases did not add reliability. The authors calculate that 8-10 21-minute long cases would give a generalizability coefficient of 0.8, using either one or two examiners. Based upon student performance on the OSCE portion of the exam, 30 7-minute stations would be needed for a generalizability coefficient of 0.73.

This is the first head to head comparison of unscripted "real" long cases vs. OSCEs. It appears that for 3.5 hours of testing, using either format, reliability is both equivalent and good. The authors cite other data that demonstrate that even long cases limited to history and presentation only, graded as was done in this study, are likely to correlate with other measures of overall competence, much like the OSCE, which measured history, physical, communication, psychiatry and radiology.

(Wow – 3.5 hours of testing. How many of you have 3.5 hours of formal objective testing – especially if it is anything but multiple choice format? The discussion on validity and reliability of testing is helpful.)
(Steve Miller, MD)

6. Journal Review
The development and evaluation of a program to teach cultural diversity to medical undergraduate students. *Dogra, N. Medical Education 2001; 35:232-241.*

This paper describes the design, implementation and evaluation of a module developed to teach cultural diversity in a British medical school. The teaching objectives were two-fold: to enable students to gain factual and practical information about other cultures and for students to examine their own attitudes. A pre- and post-module questionnaire was designed to measure differences that would reflect students' attitudinal change about melding cultures and specific cultures. Most useful in this report is the authors' detail in describing the knowledge, skills and attitude objectives of the teaching methods, the exercises utilized to attain the objectives and questionnaire used to measure degree of attitudinal change over a two-week time frame.

The authors conclude that attitudes were changed over the period of teaching, reflecting greater tolerance and understanding of cultural differences. Thus, the teaching did enable learning objectives to be met and measured. However, the study had several limitations including lack of a control group, and the inability to measure differences in behavioral change or sustained modification of personal attitudes.

It is inherently difficult to know how or whether change in attitude is reflected in behavioral change. The questionnaire used in this

study did clearly illustrate that students understand the need for cultural awareness and sensitivity. Acknowledging that we must first recognize our own attitudes in order to further value and embrace diversity is a critical piece that was successful in this report.

To my knowledge, there are few, if any, validated tools to measure attitudinal change. These authors readily share *their* questionnaire and approach to analysis. While individual programs struggle to implement their own programs and modules for teaching cultural issues, it is nice to see an evaluative approach that might be readily adapted to your own program. Furthermore, it provokes additional thought for developing measures, particularly competency-based measures, which would apply to issues of cultural awareness. For those of us working on implementation of cultural competency curricula, it is worth reviewing this issue of *Medical Education*, which focuses on recent research in this area.
Shale L. Wong, MD, MSPH

(There are some great exercises here – especially those aimed at exposing the student/doctor's innate perspective and potential conflicts with the patient's. This has been described as the key competency of humanistic doctoring. Does anyone else have a way of evaluating "cultural competency"? Is a pre and post questionnaire the best we can do? You might look at material David Keller has presented as a workshop at the APA – as a model for defining different stages of cultural acceptance. I'd love to see a feedback check list that includes – observing for culturally open communication. This is food for thought for the COMSEP Curriculum revision. (Steve Miller, MD)

Here are a few other studies for consideration:

7. Tiberius R, et al. Conversations with Parents of Medically Ill Children, *Teaching and Learning in Medicine*, 13,2, 97

This study describes a program for re – focusing language and communication – by having "non-medical" communication with parents of ill children. The authors feel that "humanism" must be taught in a way that is integrated into daily practice – not added on as tangential experiences. They also feel that students and MD's lose their normally excellent relational skills because they are forced to act as "professionals" in a cold and formal environment. I couldn't agree more – but I am not sure that their program – a 90 minute – one shot – group "chat" with a parent of an ill child – met these criteria. The participants definitely noticed how different their formal interactions were from this session – and it helped get information on the *patient's/family's perspective" – the key aspect of humanism.* Will they be able to act on this information? At least there is the potential for this.

What tricks/habits do you have to make sure you are conveying warmth – in the usually cold hospital environment? (Steve Miller, MD)

8. Parsell G, Bligh J, Recent Perspectives on Clinical Teaching, *Medical Education*, 2001; 35: 409 – 414

This is a nice overview that includes at least three important references. These are: a) Teaching Scripts and their utility, b) One Minute Preceptor and c) The key skills of clinical teaching – especially - observation and feedback. This is really just a

superficial overview of these concepts – but it has great references.

(Steve Miller, MD)

9. Medio F, et al, GME Core Curriculum, *Acad Med.* 76, 4, April 2001, 331

This is a description of a program for across specialty teaching of core curricular areas, such as ethics, to residents. How many of you have this type of program at your hospitals – and if so – is medical education part of the curriculum. It makes me wonder why most of us don't formally teach students to teach – as a way of developing a grass roots approach to promoting better teaching skills. I'm aware of some schools using fourth year students as "teachers" and developing their skills – (Larrie Greenberg at GW)
Does anyone do this formally as part of his or her 3rd year clerkship?
(Steve Miller, MD)

Richard Sarkin submitted this notice of some upcoming meetings that may have some interest to COMSEP members.

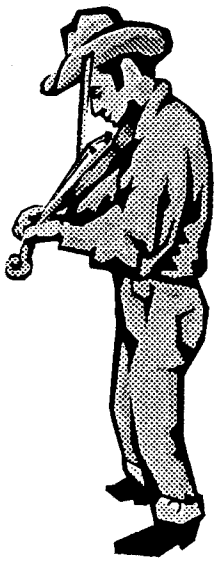
Conference for Generalists in Medical Education

The 22nd Annual Conference for Generalists in Medical Education will be held Saturday and Sunday, November 3 and 4, 2001, at the Radisson Barcelo Hotel in Washington, DC.

The theme of this year's program is "Medical Education: Progress, Problems and Priorities." The program planners are seeking program submissions that share understandings, experiences, successes, and failures in medical education. To obtain more information on the Generalists Conference visit their web site at www.thegeneralists.org/.

By the way, the AAMC Annual Meeting is also being held this year in Washington, DC, from 11/2/01-11/7/01.

Finally, because our next meeting will be in Nashville, I thought that I'd close this issue of the Educator with a list on the top 15 country hits of all time (from the perspective of a transplanted Yankee)

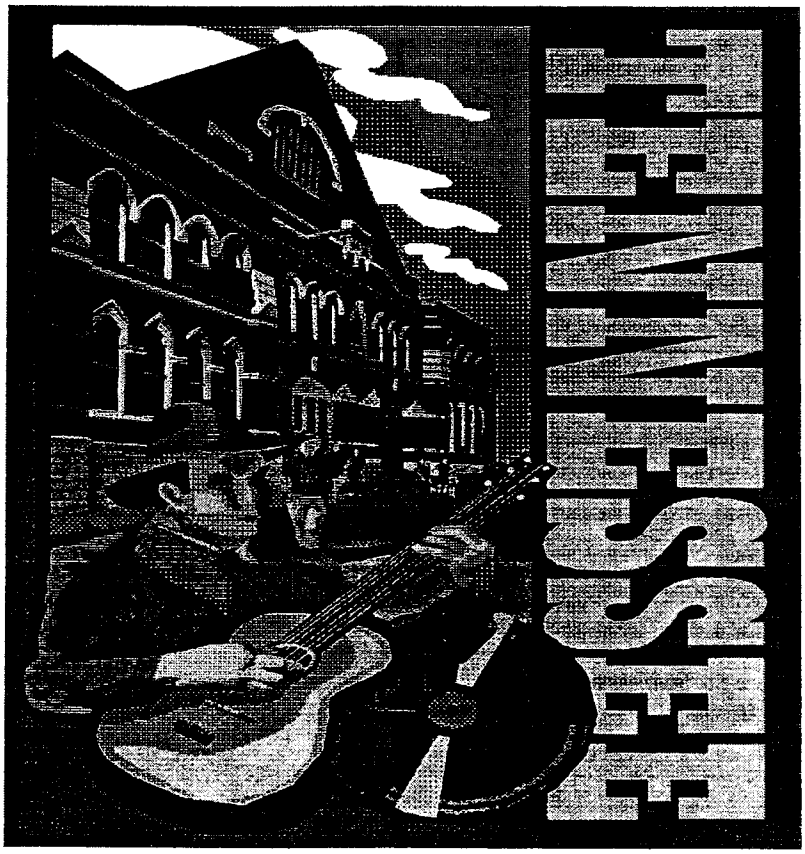


15. I Keep Forgettin' I Forgot About You.
14. I Liked You Better Before I Knew You So Well.
13. I Still Miss You, Baby, But My Aim's Gettin' Better.
12. I Wouldn't Take Her To A Dog Fight, Cause I'm Afraid She'd Win.
11. I'll Marry You Tomorrow But Let's Honeymoon Tonight.
10. I'm So Miserable Without You, It's Like Having You Here
9. I've Got Tears In My Ears From Lyin' On My Back and Cryin' Over You.
8. If I Can't Be Number One In Your Life, Then Number Two On You.
7. If I Had Shot You When I Wanted To, I'd Be Out By Now.
6. Mama Get A Hammer (There's A Fly On Papa's Head).
5. My Wife Ran Off With My Best Friend And I Sure Do Miss Him.
4. Please Bypass This Heart.
3. How Can I Miss You If You Won't Go Away?
2. If the Phone Don't Ring, You'll Know It's Me.

And the Number 1 Country and Western song of all Time is...

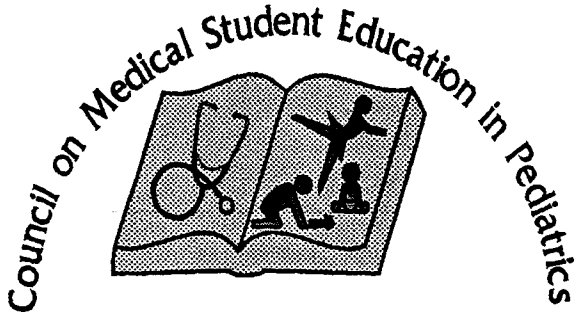
1. You're The Reason Our Kids Are So Ugly!

REMEMBER



Hilton Suites
Nashville, Tennessee
March 14-17, 2002

The Pediatric Educator



Volume 8 Issue 1 **Winter 2001**

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

Comments from our President, Richard Sarkin

Winter and holiday greetings from Western New York. I hope all goes well. I am excited about the upcoming AMSPDC/COMSEP meeting at the Sheraton San Diego Hotel from March 9-12, 2001. We have an action packed program planned including plenary sessions, task force meetings, workshops, research presentations, technology demonstrations, and plenty of time to enjoy the Southern California sunshine. I want to thank 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 session and workshop on innovations in medical education. After his terrific workshop in Vancouver, Steve Wong from UBC has been invited to address our group once again on educational aspects of cutting edge technology. You should have already received the 2001 meeting information. If not, please contact Jean Bartholomew (jbartholomew@abpeds.org).

Plans are well under way for the 2002 COMSEP meeting in Nashville from March 14-17, 2002. Bob Janco from Vanderbilt and John Estrada from Meharry will be our hosts for what promises to be another memorable COMSEP meeting.

Jerry Woodhead from the University of Iowa is leading a team that is in the process of revising the General Pediatric Clerkship Curriculum. Hopefully, the revised curriculum will be ready by the San Diego meeting. The original version of this curriculum can be found on the COMSEP website (www.comsep.org). Speaking of the website, I want to thank Jim Harper from the University of Nebraska for all of his work in revamping the COMSEP website. Efforts are underway to secure funding to keep our website state of the art and up to date.

Leslie Fall and her team at Dartmouth have received federal funding for three years

to develop comprehensive, web-based, computer-assisted instruction cases for medical students based upon the General Pediatric Clerkship Curriculum. This project is being called the "CLIPP: Computer-assisted Learning in Pediatrics Project." Several members of COMSEP are involved in the leadership of the CLIPP and the development of CLIPP cases.

Each COMSEP delegate will soon receive the just published "Guidebook for Clerkship Directors" developed by the Alliance for Clinical Education (ACE) which is a national organization composed of representatives of medical student education groups from medicine, surgery, psychiatry, family medicine, obstetrics/gynecology and pediatrics.

I want to express a very special thanks to Gary Freed from Emory who has tirelessly served as the editor of our newsletter, The Pediatric Educator, for the past 6 years. Great job, Gary, keep up the fine work! I also want to thank Steve Miller from Columbia for organizing the excellent journal reviews for The Pediatric Educator (which hopefully have been included in this issue). We are always in need of volunteers for our newsletter. Please contact Gary (gary.freed@choa.edu) if you are interested.

I also want give a most enthusiastic and heartfelt thank you to Jean Bartholomew who has so expertly coordinated COMSEP's activities since our organization was founded in 1992 and continues to do so. Jean is the glue that holds COMSEP together. I really can't imagine serving as COMSEP's President without Jean's assistance, advise, reminders and attention to detail. Jean, thank you once again.

I want to call your attention to an article by an Association of Surgical Education (ASE) task force headed by Ajit Sachdeva describing "A New Model for Recognizing and Rewarding the Educational Accomplishments of Surgery Faculty" (Academic Medicine 1999;74:1278-1287). This ASE task force created a four tier hierarchical model based on the designations teacher, master teacher, educator, and master educator as a framework to offer appropriate recognition and rewards to faculty. Criteria for various levels of achievement, ways to demonstrate and document educational contributions, appropriate support and recognition, and suggested faculty ranks were defined for each of these levels. Although the model was created for surgery departments, it is generalizable to other disciplines including pediatrics. I thought it would be interesting for each of you to read this article and see where you fit in this particular model.

One thing has become very clear to me. We need to accurately document what we do and make sure that our work gets recognized as scholarly activity. I have had multiple requests over the past several years to write letters of support for COMSEP members for promotion. I am amazed at how poorly teaching and educational activities have been documented in the materials that I receive. On several occasions, I was only able to write a strong letter based on my personal knowledge of what folks had done, rather than what they had documented.

Resources are available within COMSEP to help with the documentation process. Just as we have tried to find mentors for new COMSEP members (contact Steve

Miller at szm1@columbia.edu if you are a new COMSEP member and would like to be connected with a mentor), we would also like to find help for folks who have been involved in pediatric medical student education for several years and need mentoring as well. Karen Marcdante from Wisconsin (kwendel@post.its.mcw.edu) and Larrie Greenberg from George Washington University (larrie_greenberg@hotmail.com) are very knowledgeable and willing to provide assistance. Karen is presenting a workshop, "Promoting Clerkship Directors: The Importance of Evidence," at our upcoming meeting.

I look forward to seeing all of you in San Diego. Please contact me if you have any suggestions, comments or questions. Happy holidays!!!

Richard Sarkin
President, COMSEP
12/14/00

As Richard mentioned in his comments, plans are well underway for the 2002 COMSEP meeting. To update us is Bob Janco from Vanderbilt

"There's lots more in store than Music for COMSEP 2002!!" Mark your calendars and Palm Pilots for 13-17 March 2002 in Nashville, Tennessee. A brand new Hilton Suites will be our meeting hotel. Located across the street from the Gaylord Entertainment Center (Predators hockey) and one block from the Ryman Auditorium, former home of the Grand Ole Opry and one of the best acoustic venues in the country, our hotel has luxurious

suites at a great price. Also one block away is historic lower Broadway with honky-tonk bars, chic eateries, and a revitalized street scene that draws musicians and audiences from the entire mid-South. Rock, jazz, bluegrass, and other genres of music may be heard as well.

Across the street lies the brand new Country Music Hall of Fame where we will have a reception and private tour.

Additional activities will include a dinner, possibly at the Frist Center for the Arts, with entertainment by the world famous Fisk University Jubilee Singers. Symphony tickets may be available, and possibly ballet or opera. Bring a sweater and light jacket as the evenings are cool. Check schedules, dining, weather, entertainment, clubs, museums, maps, airports, cabs, etc at http://www.musiccityusa.com/nha.html.

We will have a booth and materials at COMSEP 2001. Come see us!"

Bob Janco
Co-host with John Estrada and Joe Gigante

The following article was submitted by Nicholas Jospe from Rochester. It is a timely and insightful article that is relevant to many of us going through the dreaded "Curriculum Change"

"Education is what remains when what has been learned has been forgotten."
B.F. Skinner.

I had the opportunity to attend the retreat organized by APGO and entitled: Women's Health Education Retreat 2000 "Undergraduate Medical Education in Women's Health: Today & Tomorrow." (APGO is the Association of professors of gynecology and Obstetrics). This retreat had an appeal for two reasons. The first was the opportunity to interface with a host of colleagues in

OB/GYN and the second relates more specifically to our curricular reform at the University of Rochester. We are designing a 'Women's and Children" Clerkship, consisting of the 2 clerkships broken up by a 2 week cycle devoted to a return to basic sciences. This cycle is the part for which I need ideas, hence the interest in attending this conference. I abstract a few sentences from http://www.apgo.org/membership/healthcare.cfm. The APGO WHEO hosted an interdisciplinary Women's Health Education Retreat on November 10-12, 2000. A total of 88 multidisciplinary participants representing over 40 women's health organizations, ob-gyn specialty societies, government agencies, the National Centers of Excellence in Women's Health and a number of medical schools, attended the retreat.

The retreat facilitator, LuAnn Wilkerson, EdD, did an outstanding job of leading the large group throughout the weekend and moderating many of the discussions. In brief, the intent was to lay the foundation to put together a multidisciplinary "writing group" to take those foundation documents, the priority areas identified and synthesize them into domains of critical knowledge in women's health that every graduating medical student must master by graduation. These domains were selected specific enough that they can be measured, identified in the curriculum and tested for by the USMLE and evaluated for inclusion by LCME, yet open enough that rapidly changing information and discoveries, as well as the individual school variations can be accommodated.

The primary goal for this meeting was to elaborate a core curriculum, which was done in small groups. Suggestions were made and voted on. These related to skills, knowledge, attitude, etc. There was also attention paid to improving the national clearinghouse of resources, in order to make all of these available to all. There was a workshop on designing and writing questions to reflect women issues. The instructions were very specific in pointing out that sensitivity to women's issues needed to be attended to. For example, a young girl with diabetes and bulimia and blood glucose levels out of control. We realized how relatively easier it is to write a question about anybody's diabetes or compliance or stress, than it is to develop a question that stretches the student to think about women's issues within that context, of say, diabetes or compliance or stress. As well, there was a very informative discussion by Sandra Kweder, MD, from the Center of Drug Evaluation and Research at the FDA, on the subject of inclusion of women in pharmacological research studies. Finally, the keynote speech was given by Dr. Daniel Federman. He is the senior dean for Alumni Relations and Clinical Teaching at Harvard Medical School. Dr. Federman discussed not so much women's issues as the lessons he has learned about curricular change and implementation during his remarkable career. He gave a singularly inspiring/insightful discussion about educational reform. As we are in the middle of curricular reform at the U of Rochester, this was also very timely for me. He talked about "orchestrating discontent," providing "vision but inspiring participatory implementation." He talked about institutional values and explained that content and

pedagogy feed on one another. In discussing education reform, he advised against a single national model of curriculum. He explained to that people usually don't like it and that schools are different. Rather, his suggestion is to inspire "generally but expect variations locally and support locally relevant effort."

I came out of the conference with a few ideas which I found enticing. One is the following. All clerkship students would collate what they actually learned from their reading, their accomplishments and their teaching. Each student would come to the exit interview saying what he or she had really learned during the clerkship no matter how incomplete. This student curriculum would be contrasted with the COMSEP curriculum or the curriculum of that particular clerkship, from the student perspective. This would be analogous to an academic log. It could also work on line. Another suggestion is to ask a student to give a talk on women's health issues related to pediatrics. For example, contraception, female circumcision in Africa, sexually transmitted diseases and so forth. The idea is to ask students to give one generic pediatric curricular talk and one unique talk not directly related to the usual pediatrics "stuff." Another suggestion, because of the need to beware of the emphasis on geriatrics within traditional obstetrics and gynecology clerkships is to actually incorporate female medical students as SPs.

Finally, I was impressed that the collaboration with industry seems to be particularly good. APGO actually has a corporate liaison committee.

Nicholas Jospe

Kim Blake, from Dalhousie University in Nova Scotia, had some of her students submit the following:

Bright Lights, Big City

A conference is an exciting and eye-opening event for any medical student. It is a chance to go from the relatively sheltered lecture theatre or clerkship rotation to a place that offers exposure to fresh ideas and inspiration.

We had such an opportunity during our attendance at the Association of American Medical Colleges 11th Annual Meeting held in Chicago in October of 2000. The thought of participating in such a prestigious conference as students was initially daunting, but with encouragement and support we succeeded and had an invaluable experience.

In our 3rd year clerkship (1999-2000) a community project had been introduced into the pediatric rotation at Dalhousie University and we were involved in evaluating the class' response. We worked closely with the Pediatric Undergraduate Director, Dr. Kim Blake, who suggested that as a group we should consider submitting an abstract of our work to be presented at the AAMC Innovations in Medical Education (IME) Exhibits.

The IME Exhibits encompass a mixture of innovations ranging from continuing medical education, faculty development programs, and computer applications in medical education to community-based initiatives like ours. Exhibitors display their posters in booths and use additional media such as computers, projectors, and models to enhance the presentation. The IME exhibits are open for viewing for three consecutive days during the course of the six-day conference.

We submitted an abstract (which is assessed by a committee but is not peer reviewed) to the IME

Exhibits that described the community project and the class evaluation. Guidelines, submission deadlines and fees were easily accessible on the AAMC web site (www.AAMC.org). Once our abstract was accepted we began preparing the poster and thinking about finances.

We greatly appreciate funding from the Department of Pediatrics, Dean's Office, and Division of Undergraduate Medical Education at Saint John NewBrunswick (one of the community hospitals). However, as all three of us wanted to attend we had to pay a fair amount individually. Hidden costs e.g. the electricity fee to run our power point presentations and the booth cost all added up. In retrospect, we may have been able to secure more funding if we had allowed ourselves more time to explore potential resources. Overall, the conference was a terrific experience for us. The size of the conference and the wealth of universities and researchers involved amazed us. We shared our community project experience with people from Canada, Europe and US and learned about other interesting innovations in medical education. We were particularly impressed with the quality of the Research in Medical Education (RIME) poster and oral presentations. We could personally relate to the research and we gained practical insight into effective poster design and presentation tactics.
The experience we had at the AAMC will remain with us for the rest of our medical careers. With enthusiasm and direction from Dr. Kim Blake, we were able to go from a medical school project to participating in an international conference. We feel that attendance at the AAMC Innovations in Medical Education Exhibits has the potential to be a very rewarding opportunity and recommend that medical students and medical educators explore this possibility should the chance arise.

Elizabeth Stringer, Robbie Stewart, and Julia Carroll.
Fourth year medical students at Dalhousie University.
For more information contact Kim Blake-Kblake@Is.Dal.ca.
or

Fred McCurdy, from the Univ. of Nebraka, updates us on the activities of ACE

ACE

"The Alliance for Clinical Education's mission is to foster collaboration across specialties to promote excellence in clinical education of medical students."

The Alliance for Clinical Education (ACE) came into existence in 1992 largely through the efforts of COMSEP Past-President O.J. Sahler. O.J. recognized that medical education was being constantly threatened by increasing demands on faculty time to provide more clinical revenue and decreasing emphasis by government and medical schools to guard the "streams" of funding that paid for medical education and medical educators. She believed that there was strength in numbers and sought to organize the leaders of clerkship director organizations in order to work collaboratively toward solving common issues and problems. Therefore, ACE – a consortium of clerkship director's organization – came into being.

The by-laws of ACE allow each clerkship organization to nominate 4 members to serve on the ACE board. The current ACE board members from COMSEP are Bruce Morgenstern, Nan Kaufman, Roger Berkow, and Fred McCurdy. The board meets

every year in conjunction with the Association of American Medical Colleges Annual meeting while the Executive Committee (one representative from each constituent organization) holds a conference call 6 times per year. The current President of the Board is Fred McCurdy. This is the second time Fred has been the President. His three-year term will expire in 2001.

ACE has an active membership and maintains a busy agenda. It has accomplished publishing a New Clerkship Director's Handbook that is in its second edition. In fact, COMSEP has been promised 150 complimentary copies that will be distributed to each COMSEP Delegate. ACE has also signed an affiliation agreement with *Teaching and Learning in Medicine* offering a discount subscription to all COMSEP members (further information on this offer should come soon from the COMSEP administrative office). Additional benefits of the affiliation agreement are being discussed, but it is certain that these discussions will lead to future opportunities for the work of COMSEP to be published in a peer reviewed journal.

The ACE Board has been working very hard to complete the writing of a mission, vision and values clarification document. This will be used to guide future strategic planning. COMSEP members have had a very active role in accomplishing this task and more will be forthcoming on this project. Suffice it to say at this time, ACE is taking a hard and long look at the original issues that prompted its formation.

If you have questions or comments about the work of ACE, please contact any of your ACE representatives. They will be happy to assist you in whatever way they can.

Fred McCurdy

Leslie Fall, from Dartmouth, updates us on the "CLIPP" project

CLIPP
Computer-assisted Learning In Pediatrics Project

Norm Berman, Leslie Fall and Ardis Olson

The General Pediatric Clerkship Curriculum, developed by COMSEP and the APA in 1993, provides the framework of teaching objectives used by most pediatric clerkship directors in structuring their student curriculum. The curriculum itself (other than the clinical problem set) is not a teaching methodology, however, and many within COMSEP have recommended the national development of teaching methodologies that will provide students with the curricular content in a consistent manner and promotes clinical reasoning and self-directed learning skills. In addition, increasing use of community and distant sites requires many of us to develop innovative ways to insure that all of our students learn the core objectives and are exposed to the full range of general pediatric problems. The use of new technologies, such as Web-based computer-assisted instruction (CAI), to deliver the curricular content in a consistent, efficient and interactive manner to students in clerkships across the country has been suggested.

The Computer-assisted Learning in Pediatrics Project (CLIPP), funded by the Bureau of Health Professions through a pediatric predoctoral training grant will provide pediatric clerkship directors throughout the country with an innovative, computer-assisted learning program, based comprehensively on the COMSEP curriculum and accessible to all students via the Internet. When completed in the spring of 2003, the

CLIPP Learning Program will consist of 30 interactive computer cases each designed to take approximately 30 minutes to complete. Each case will include multimedia, a variety of question and answer screens and a clinical reasoning tool. To accomplish this, CLIPP has 4 objectives: 1) to define the content, scope and priorities for the learning cases through a national consensus of the pediatric educators of COMSEP; 2) to develop and author the computer cases which encompass the comprehensive learning objectives of the CLIPP program; 3) to implement and pilot CLIPP at 2 medical schools and then to disseminate the full program nationally; 4) to evaluate the accessibility and educational feasibility of CLIPP as it is progressively implemented.

The project is structured to ensure that the final learning program will meet the teaching and learning needs of the majority of COMSEP schools. Much in the same way as the original COMSEP curriculum was developed, CLIPP will rely on a consensus developed through project advisory groups made up of key COMSEP leaders, as well as inviting input from the COMSEP membership at key times in development. The project's Advisory Group, composed of the DMS project team and leaders of the Curriculum and Technology Task Forces, is overseeing the entire development process. The Content Working Group, composed of members of the Curriculum Task Force, is turning the COMSEP curricular objectives into the core outlines of the 30 cases. The Computer-Assisted Instruction Group, made up of members of the Technology Task Force is developing the authoring guidelines and tutorials that will ensure that the cases are developed in a manner that best utilizes the technology and multimedia. Finally, a process for case peer review and open review by the COMSEP membership is being developed.

The development of the CLIPP Learning Program is a 3-year process, ending in July of 2003. This first year has been spent determining the content of the 30 cases, developing the authoring guidelines and tools, and planning the evaluation and peer review process. In addition, members of the various CLIPP working groups are authoring 6 pilot cases. Pilot testing at Dartmouth has begun and will begin at a second COMSEP school in July. Years 2 and 3 will see the staged authoring of the remaining cases as well as continued pilot testing, outside peer review and open review of the cases by all interested members of COMSEP.

To date, development of the overall learning program objectives and content outlines of each CLIPP case is now largely completed and will soon be available on the COMSEP web site. In developing these, the members of the CLIPP Advisory and Content Groups felt strongly that CLIPP needed to focus on what is realistically achievable rather than what may be ideal. To be most effective as a comprehensive learning program, an average student should be able to complete the entire set of cases during their clerkship. We recognized that this places significant constraints on what can be incorporated into a CLIPP case. Work now begins on Objective 2. CLIPP cases will be authored by members of COMSEP using CASUS, a case-based authoring software program. CASUS is the product of several years of development by a multi-disciplinary group of physician educators and software engineers in Munich, Germany. CASUS enables

physicians and other medical educators to produce sophisticated Internet-based learning cases with a minimum of technical effort and skill. Despite the relative ease of authoring, CASUS provides for truly interactive CAI, including an ability to teach diagnostic and clinical reasoning through a unique feature of the software.

We will be recruiting case authors in 2 stages. The first group who responded to our "Call for Authors" on the listserv will be attending an authoring workshop at the San Diego COMSEP meeting. Each author will be assigned a case in advance, preferably in an area of his or her expertise or interest. Authors will be given hands-on instruction in both the authoring process as well as use of the CASUS software and will begin working on their assigned cases with direct "mentoring" from members of the CLIPP technology and content groups. When authors return home, they will receive ongoing technical and authoring support. The CLIPP support staff at Dartmouth will provide software support and will also obtain multimedia components as needed for each case.

Evidence in the literature as well as our own experience at Dartmouth has shown that the mere availability of computer-based teaching cases is not enough. Formal integration of into the clerkship curriculum, including student evaluation, is vital. To this end, the entire CLIPP program, as it is developed, is being pilot tested at Dartmouth and a second COMSEP school. This will allow student-level feedback on the learning program as well as helping us determine the best way to recommend integration to the COMSEP membership when the full CLIPP program is launched at the March meeting in 2003.
The overall evaluation of CLIPP is largely centered around ensuring that the authored cases are educationally sound and that implementation is feasible. This is being achieved a number of ways. First, all cases will be fully integrated into the clerkships at the pilot schools. Secondly, each case will be sent out for formal peer review with both a content expert as well as with a pediatric educator versed in computer-assisted instructional methodology. Finally, each case will be available on the COMSEP web site for open review by the COMSEP membership prior final approval by the CLIPP Advisory Group.

The CLIPP Learning Program will ultimately be "launched" at the COMSEP meeting in March 2003. We anticipate that the program will be available to all COMSEP member schools and their medical students free of charge through a password protected web site which will be reached on its own as well as linked to the COMSEP web site. Once implemented we hope that ongoing research regarding the effectiveness of computer-assisted instruction in medical student education using CLIPP will provide the fruit of future collaborative projects.
Questions regarding CLIPP can be directed to any of us, either through our individual e-mail addresses or at . We look forward to working with all of you on this exciting new project.

Leslie Fall

The next section of the Educator is devoted to reports from the various Task Forces

Research Task Force: Cynthia Christy, Rochester

The Research Task Force will be meeting again at the COMSEP meeting in March. We are interested in collaborating with the other Task Forces on research projects and are available to consult with individuals with questions about their projects. Last year at COMSEP, a workshop was devoted to research projects and we were happy to have Kim Blake, Bob Swantz and Jim Harper present their projects for discussion. Right now we are awaiting the abstracts submitted for this year's meeting. These "Innovations in Education" abstracts are to be sent to Lorrie Basnight by email (BasnightL@mail.ecu.edu) by January 19, 2001. There will be both oral and poster sessions to discuss the projects of our members. The focus of submissions should be on education, new methods of teaching, new student programs, curriculum changes, techniques for student evaluation, and the use of technology in education.

Cindy Christy

Evaluation Task Force: Roger Berkow, UAB at Birmingham

Since the last Pediatric Educator was published the activities of the Evaluation Task Force has centered on the Listserv discussion of the "Chairman's Letter" and the development of a uniform method of transmission of information about students seeking positions in pediatric residency programs. Stuart Slavin has been working on this project. The other area of continued activity is with the National Board of Medical Examiners. I am pleased to announce that COMSEP continues to be represented on Several NBME committees. Mike Lawless has been appointed to the USMLE Step 2 Test Material Development Committee for Pediatrics, and I will assume the position of Chair of that committee. Similarly Paula Algranati remains active on the USMLE test Material Development Committee for Standardized Patients. We will continue to work hard to have the COMSEP curriculum be a guide for national evaluation methods in Pediatrics.

Roger Berkow

Curriculum Task Force: Jerold Woodhead and Jane Curtis

The revision of the APA/COMSEP General Pediatric Clerkship Curriculum that has been planned for some time is now (finally) underway. A number of COMSEP members have reviewed the different sections of the Curriculum document and have made suggestions for revisions and updates. A working group drawn from the larger task force will meet the weekend of January 6-7, 2001 at Wake Forest University to go over these suggestions and to develop a proposal for changes to the Curriculum. Mike Lawless has agreed to host this working group.

We all have learned a lot about using the Curriculum since it was introduced in 1995, and we have identified its strengths and weaknesses. Many COMSEP members have modified the basic document for use in their individual clerkships. Some use the Curriculum as a guide for education about Pediatrics across the entire four years of medical school. The beauty of the document is its flexibility for use in many different applications and settings. But we know that it needs to be updated.

While the working group has not reviewed all of the Curriculum variants, many of these modifications have been used to identify the areas in

the original Curriculum that are in need of updating -- including missing topics, needed revisions, and better ways to present the materials. All of the sections will be reviewed and discussed at the meeting in January. The working group will be charged to incorporate new ideas, to update objectives and competencies, and to revise the clinical problems that accompany each section. We will strive to keep the overall length of the Curriculum close to that of the original document. This working group will not address the Resource Manual, although it is in need of revision, too.

It remains to be seen whether the changes to the Curriculum will be completed in time to present them at the annual meeting in San Diego.

COMSEP members who have contributed substantially to the review process include the following (the * indicates those whose schedules permit attendance at the January meeting). I should add that many other COMSEP members not listed below have assisted with the revision project:
Roger Berkow
Cindy Christian *
Jane Curtis
Scott Davis
Mike Giuliano *
Jo-Ann Harris (liaison from the Technology task force)
Nan Kaufman *
Mike Lawless *
Lynn Manfred *
Kathleen McGann
Bill Raszka
Randy Rockney
Jerry Woodhead *

Jane Curtis deserves much credit (and my thanks) for her willingness to work on this project. Her energy and hard work really gave it a jump-start!

Any COMSEP member who has suggestions for updates to the Curriculum may send them to me. In addition, anyone who wishes to join in on the work to revise the Resource Manual should also contact me. We will have much to do during the upcoming year.

Jerry Woodhead

Learning Technology Task Force: Robin Deterding

Greetings to everyone! This is a brief update on the Learning Technology Task Force (LTTF). Since the 2000 COMSEP meeting our activities have focused on establishing funding for the COMSEP website, identifying clinical recognition skills, participating in the CLIPP project, surveying about technology educational needs, and developing the program for the 2001 COMSEP meeting.

We continue to develop the website proposal and are optimistic that this will be funded. The goal will be to develop and share information that focuses on pediatric medical student education. Once funded, we will need your input about what information and digital activities you would find most useful. If you have ideas now please forward them to me and be ready to discuss these exciting possibilities at the COMSEP meeting!

Though at first blush clinical recognition skills may not seem technology related, the assessment of clinical recognition skills requires multimedia. As we start to create multimedia teaching material this information will be very important and hopefully will appear in the revisions of the curriculum. I have forwarded the input I received from my list-serv inquiry to the curriculum committee but if you would like a copy just e-mail me. This will also be helpful to the CLIPP project. As most of you are receiving information about CLIPP I will not go into great detail here.

Carol Kamin completed a COMSEP Technology Needs Assessment through the list-serv to better understand the educational needs of our members. Thirty-two people responded. In general most respondents felt very comfortable using e-mail, word-processing and creating basic power-point presentations and excel spreadsheets. Most respondents also felt comfortable using PubMed or Medline for searches but were significantly less familiar with the Cochrane (evidence based medicine database) or educational (Eric) databases. There were clear needs related to the creation of multimedia teaching materials and the use of personal digital assistants (PDAs or handhelds). Less than 35% of those responding felt experienced in these areas. A full report will be available at the national meeting and presented in the LTTF meeting.

The good news about technology and the COMSEP meeting is that the sessions planned will address many of the identified areas of need! There will be 2 sessions on PDAs and a show and tell workshop on technology projects being used by our members. We have also put together an exciting pre-conference workshop for hands on experience in creating videos for teaching. Our creations should be very entertaining for the conference!

I thought I would end with a few links that I have used. I recently gave a talk on the use of technology in medicine with many more active links in my handout. If you would like a copy of the handout just e-mail me.
Looking forward to seeing everyone at COMSEP!

Medical information sites:
http://www.medscape.com
Site for MDs for health news, abstracts, and about everything
Medscape's MedPulse [news@medpulse.medscape.com]: current Medscape selected abstract reviews
www.FreeMedicalJournals.com free journals on line and updates of topics you select
http://www.pdamd.com a good reference for MDs to check new information
http://www.rarediseases.org/lof/lof.html a great site for rare diseases
Evidence based medicine sites:
http://www.cochrane.org/cochrane/revabstr/g150index.htm free abstracts of reviews

Robin Deterding

Faculty Development Task Force: William Wilson

The Faculty Development Task Force will meet at the 2001 COMSEP Annual Meeting in San Diego on Saturday, March 10 and Monday, March 12. The program for the annual meeting includes a number of workshops by participants in the Faculty Development Task Force, in part reflecting the activities and discussions at the previous Task Force meeting. Among the current activities of the group are the journal review and the mentoring project, both coordinated by Steve Miller. We welcome all COMSEP members to participate in this Task Force; come prepared with enthusiasm and ideas for the upcoming year.

William Wilson

Dr. Wilson also submitted the following "news brief"

Genetics in Primary Care Initiative.
Several COMSEP members were members of teams from their home institutions that were awarded grants under the Genetics in Primary Care initiative. A planning/ educational meeting for the teams was held in Chicago in October, with another scheduled for the spring.

Paula Algranati shares with us her experiences in developing a video tape to be

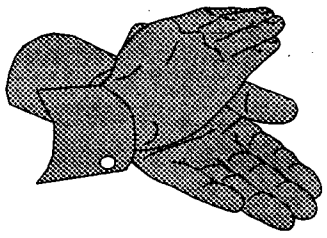
used for teaching Pediatric physical diagnosis

THE DEVELOPMENT OF A VIDEO TAPE FOR USE IN TEACHING PEDIATRIC PHYSICAL DIAGNOSIS. Paula Algranati, MD University of Connecticut

Inspired by the exciting results of work by fellow COMSEP members, and by a long-standing commitment to clinical skills teaching, I recently designed a proposal to produce a pediatric physical examination videotape. Awarded a Kaiser Permanente grant from the University of Connecticut, I originally planned to film 5 physical exams on healthy children from newborn through adolescence. A contingency from the award committee fortuitously led to what promises to be a unique strength of this project. I was requested to identify a medical student who would be integrally involved and not merely a project consultant. Recruiting Amelia Hopkins, one of our senior students, was a huge bonus. Using a variety of sources including my own text, Amelia composed and memorized her own scripts. As the clinician on film, speaking to fellow students, she beautifully outlined overall goals for content and sequence and deftly demonstrated the mechanics of examining healthy children. We recently completed filming two exams on a healthy newborn and a healthy two year old. Since filming and editing time proved so costly, we deferred filming other age groups for a future project.

Bill Hengstenberg, the director of our video communications department, contributed considerable manpower and expertise for the other unique aspect of this project. With a camera crew of 6, each examination was filmed twice, once to demonstrate the entire sequence and a second time so that close-ups could be spliced in when appropriate. His department will also guide us in editing and voice-overs. We are planning to introduce the films for use in our clinical skills course along with an evaluation instrument to assess impact, and will also provide a copy to each clerkship site. I will bring a copy to this year's COMSEP meeting and welcome the opportunity to share this with colleagues and receive feedback. If there is interest, I will pursue avenues to fund copies for COMSEP members who desire them.

And now, I am pleased to present the "Steve Miller Show"! Once again Steve has done a great job. He will provide us with information on SIG, the COMSEP Mentoring Program, as well as the outstanding literature review that has become the highlight of the "Educator" over the past few years.



Medical Student Education SIG

The APA SIG is the birthplace of COMSEP. The tradition of the SIG is that all participants will:

A) Learn something new to take home with them.
B) Develop a product in collaboration with other SIG participants.
C) Participate in scholarship through the work of the SIG.
D) Have fun

<u>Program 2001</u>
Competency based evaluation has become a buzzword in medical education circles. We will explore how organizing evaluation strategies – via

explicit competencies – enhances our approach to assessment. A number of COMSEP members will participate in leading and facilitating the program – including Lindsay Lane, Jane Curtis, Bill Raszka, Helen Loeser and others.

The goals will be to learn how to organize evaluation around defined competencies and to develop an evaluation tool for a competency that is part of the COMSEP curriculum.

The format will include three critical components.

1. Brief review of concepts of competency based evaluation from experts in the field, including (but not limited to) OSCE's, Standardized Patients, Oral Exams and Written exams.
2. Group work to develop a template for competency based evaluation of skills that are part of the national curriculum for students (COMSEP). This has relevance for residents as well.
3. Organizing collaborative work for the entire year, in the spirit of the Physical Examination Video.

General Program

1. Overview: The program will begin with a brief update from relevant organizations related to medical education.
2. Posters: We will also have time for poster presentations (submit any ideas – including program descriptions and new ideas) – this is a terrific forum for first time academic forays in a friendly environment.
3. Program 2001: Competency Based Evaluation
4. Update: New ideas, Palm sharing and general discussion.
5. Next Year: Setting next year's agenda – and work for the year 2001-2002.

Contact me at:
for any suggestions or to volunteer to help.

COMSEP Welcoming and Mentoring Programs

We are happy to continue our efforts to create a cohesive environment to foster collaboration and communication. These fledgling efforts will continue this year in two formats.

1. **Welcoming Program**

New and relatively new members will have a number of opportunities to meet "older" members - in order to find out how to get the most out of the meeting, how to get the most out of the group and how to grow a career as medical education. There will be a number of opportunities to do this.

1) COMSEP Hospitality Suite:
Friday, March 9-Noon - 10:00PM

Noon - 1PM and 5PM - 6PM
Experienced members of COMSEP will be available to greet newer members.

2) Pre Conference Workshop
Friday, March 9-1PM-5PM

Workshop for New or (This might mean relatively new - or even if you have been at it for a while and want to revisit the nuts and bolts) Clerkship Directors. This is a terrific experience - it speaks for itself.

3) Lunch with Experts
Saturday, March 10 -12 - 1:15 PM

Experienced members of COMSEP will facilitate discussion among members.

2. **Mentoring Program**

Newer members - or anyone interested in developing a mentoring experience -should email me at zm1@columbia.edu. Someone will contact you in February to meet at the meeting. Some of you have already sent in your requests - but to facilitate accuracy - please send them forward again.

Thanks - please provide feedback about how to improve the program to any members of the executive committee - in particular - Stu Slavin, Helen Loeser or myself. Thanks - Steve Miller

Pediatric Educator Review

Welcome to our fifth journal review. I'd like to acknowledge Karen Wendleberger - Marcdante 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 – regardless of your experience - so let me know if you want to serve as a reviewer next time.

Please, e-mail me at or through the COMSEP listserve with your comments. (Steve Miller, MD – Columbia University, NYC)

Editorial Board: Steve Miller, MD and Lindsay Lane, MD
Reviewers: William Wilson, MD, Chris Maloney, MD, Bob Janco, MD, Kim Blake, MD, Sheila Woods, MD, Steve Miller, MD, Lindsay Lane, MD

1. Humanism: Is Its Evaluation Captured in Commonly Used Performance Measures? Coutts, Louisa, Rogers, John C. ***Teaching and Learning in Medicine 2000; 12:28-32***
Department of Family and Community Medicine
Baylor College of Medicine
Houston, Texas USA

The authors assessed 428 third year medical students during their Family Medicine clerkship using students performance data from clinical preceptors, standardized patients(SPs), written exercises including OSCE (Objective Structured Clinical Examination)station written portions and a home visit report, and finally, the National Board of Medical Examiners Family Medicine examination. The clinical preceptors rated students on data and technical skills, knowledge and problem solving, relationships with professionals and patients, educational attitudes, initiative and interest, and attendance and dependability. Standardized patients rated student performance during an OSCE on interview style, history taking, physical examination, management negotiation, and patient education. Written exercises in the OSCE assessed students' differential diagnoses, management plans, and identification of ethical principles. In addition to the standardized patient encounter checklist, the standardized patients also completed a separate 8-item humanism questionnaire on each student. This abbreviated Physician Humanism Scale was developed by FR Hauck and published in *Family Medicine 1990;22:447-52.* The students were rated by the SPs on a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree) on such items as "This doctor seems to take a personal interest in me" and "This doctor respects my beliefs".

The most interesting results from this study were that students' humanism scores significantly ($p<.02$) and

positively correlated with ALL of the measures of clinical performance and knowledge assessment. Despite their significance, however, the correlation coefficients between humanism and the measures of clinical performance were low, ranging from .12 for the NBME examination to .31 for history taking. Intuitively, assessments of performance, particularly those based on subjective rating by preceptors and standardized patients, may well overlap humanism scoring. Humanism scoring, however, can still provide separate and additional information that the current NBME examination can not. The authors note also that nine students who scored extremely poorly for humanism, passed their clinical preceptor's rating, and eight of them passed the NBME examination, lending credence to the addition of independent measures of humanism in medical education. **(Sheila Woods, MD)**

This study has a terrific background discussion on humanism and it is yet another confirmation of the Hauck Humanism Scale as a valid and reliable assessment tool. I wonder if we should incorporate these 8 items into our assessment of students – and begin to seek out peers, nurses and patients as evaluators. What do you think? Without this – 8 "antihumanistic" students would have been missed – and sent out to torture our loved ones. (Steve Miller, MD)

2. Quantifying the Literature of Computer-aided Instruction in Medical Education. Adler, M.D. and Johnson, K.B. 2000. ***Academic Medicine, 75 (10): 1025-1028.***

This study searched Medline and ERIC (Educational Resources Information Center) using key words, to identify journal articles related to the use of computers as an aid to medical education. Their goal was to identify the number of articles falling into the following categories: Demonstration – descriptions of the computer aided application, Media-comparative – comparison of computer aided techniques either to other learning methods or other computer aided applications, or Analytic – evaluation of an aspect of the computer aided application. Only if an abstract could be retrieved electronically, and it was in English, was an article included in their evaluation. The first author assigned each article into one of the above groups and the second author, to evaluate inter-rater reliability, reviewed and categorized 10% of the abstracts. Of the 2763 articles from the initial retrieval, only 1498 met the inclusion criteria. The authors identify an increase in computer-aided instruction (CAI) citations since introduction of the personal computer in 1982 and the number of citations has remained steady since 1992. Sixty percent of the articles were categorized as demonstration, 11% were media-comparative, 13% were analytic and 16% could not be classified into any of their three categories. The authors conclude that the medical literature does not need additional demonstration articles, but needs more studies that are media-comparative or analytic. They suggest that more rigorous peer review processes would limit demonstration articles and that additional resources should be allocated for critical evaluation of CAI as an educational tool in medicine.

This article provides insight into the evaluation process (or the lack of documented evaluation) of computer-aided applications as instructional tools for medical education, although their methodology does contain flaws. The

authors acknowledge that controlled studies comparing CAI to traditional educational processes are difficult to complete and fraught with internal bias. Likely the best way to evaluate CAI is to directly compare one application to another CAI tool. Determining the outcome to measure may occasionally be difficult, but potential measurable outcomes include economic impact, structured approach to a standardized simulated patient or case, and changes in recall or recognition. CAI offers advanced interfaces to incorporate multimedia into the educational process and to provide context-based learning.

As a graduate student in medical informatics I offer the following scale to evaluate computer applications (modified from Reed Gardner, Ph.D. Chairman, Department of Medical Informatics, University of Utah):

1. Sharing an idea
2. Development of a prototype
3. Testing of a prototype
4. Evaluation of the prototype
5. Modification of the prototype
6. Delayed evaluation
7. Does the tool Change Student Behavior
8. Does the tool Change Patient Outcome
9. Can the process be Exported

I believe we need to be performing studies of CAI in medical education that fall into the last three categories. If an application can change student behavior or patient outcome, then we should perform multi-centered trials to determine if the educational tool is functional beyond institutional boundaries. **(Chris Maloney, MD)**

This study provides a long list of why most people publish demonstration studies in medical education – and it openly challenges us to do more rigorous research – that demonstrates real outcomes. Once again – the question of what constitutes scholarship rears its (?ugly?) head. Do you think demonstration articles are useful? Have they given you new ideas? Do they represent "scholarship"? And finally – what would it take for us to move up the research ladder – to more traditional (?rigorous?) scholarship? Check out the reasons given in this study – which -by the way - is itself a "demonstration" study of where the literature is – without any "outcome". (Steve Miller, MD)

3. Adoption and failure of the "Boyer model" at the University of Louisville, Schweitzer, L. *Academic Medicine 75: 925-929, 2000.*

This paper is a "cautionary tale" recounting an attempt at one institution to broaden the definition of "scholarship" to give a more balanced view of academic work (including teaching) and, by extension, a broader means of assessing the efforts and success of members of the medical school faculty. As the title implies, this particular attempt was not successful. In a refreshingly candid style, Dr. Schweitzer provides institutional history leading up to the proposed changes, the modifications that were adopted, problems that were encountered, and her analysis of the reasons for lack of success of these changes. Even though the overall process was not successful, there were gains in terms of the types of papers, presentations, abstracts, and funding acquisition that became acceptable as means of demonstrating scholarship. Given the interest among COMSEP in promoting careers as physician-educators and the current discussions regarding reform

in the promotion and tenure process in many institutions, this paper is worthy of close scrutiny. **(William G. Wilson, MD)**
This is must reading for everyone who is entertaining an academic career. The Boyer criteria – and its modification at Louisville – is terrific information for anyone who can influence the promotions criteria at their school. The "generation of new ideas and its acceptance/dissemination through peer reviewed/accepted means" is the key concept. The Louisville experience points out that – ironically – attempts to add 'teaching" as a scholarly activity – don't shift the emphasis away from traditional outcomes based research (see the Adler study above) – rather, it forces more rigorous documentation of teaching. How many of you has an Educator's Portfolio to add to your CV – and will your promotions committee look at it? For more on Educator's Portfolios – look to MC – Wisconsin and our own Karen Wendleberger-Marcdante. Meanwhile – evaluate all of your teaching and save it in a file – to document your "dissemination" of ideas. (Steve Miller, MD)

4. In-training Assessment - Its potential in enhancing Clinical Teaching"
Spike et al., *Med Ed 2000; 34: 858-61*

This manuscript is the product of a literature review and discussion by an expert working group at the Ninth Cambridge Conference on issues related to In-Training Assessment (ITA) that could be applied to improve clinical teaching. The expert working group included representatives from a number of Australian universities, the University of Hong Kong and the University of Sheffield. The corresponding author, Dr. Neil Spike, is an official with the Royal Australian College of General Practitioners.

This paper is a thoughtful, well referenced perspective on the utility and obstacles to using ITA in the evaluation of clinical performance, such as in a clinical clerkship in Pediatrics. ITA is a well-established tool in other domains which is increasingly popular as an evaluation tool in undergraduate medical education. The working group noted that ITA offers benefits for the learner, the teacher and to the educational program. This is notable as ITA can be both systematic (as part of a formal evaluation process) and opportunistic (taking advantage of clinical encounters) and can be based on direct evidence (such as observation) or indirect evidence (such as chart reviews). However, in order to achieve these benefits there are three issues which must be addressed prior to implementation of ITA as an evaluation tool, these being training of assessors, evaluation of the validity and reliability of assessor ratings and documentation of the ITA encounter. The working group also noted that many of these issues have not been evaluated in the medical education literature, despite the increasing interest in ITA for both formative evaluation and high-stakes examinations.

This manuscript offers the neophyte medical educator an excellent perspective on a controversial issue and provides those salty old dogs among us with more bones to chew. I highly recommend review of this manuscript for those clerkship coordinators thinking about incorporating ITA into their evaluation formats. **(Michael J. Rieder MD Ph.D**
Department of Paediatrics, University of Western Ontario)

How many of you are

satisfied with how you collect data on the students' day to day performances? This article identifies three critical components of valid daily (in training) assessment of learners – a) assessor training, b) assessor rating criteria and c) documentation of encounters/assessments. Two key points that you will see are 1) great references on how to train assessors to be more rigorous – that is – avoid the" halo effect", stereotyping, leniency/stringency, and scale shrinking – and 2)how to use global ratings to simplify the process. Also – check out Larrie Greenberg's encounter cards as a means for documentation. What other ideas do people have regarding assessing the day to day work of students? (Steve Miller, MD)

5. The Script Concordance Test: A Tool to Assess the Reflective Clinician.
Bernard Charlin, Carlos Brailovsky, Louise Roy, Francois Goulet, Cees van der Vleuten
Teaching and Learning in Medicine, 12(4), 189-195

This is one of a series of articles that describes a new method to assess clinical competence. The authors are from Montreal (Goulet), Quebec (Charlin, Brailovsky, Roy) and the Netherlands(van der Vleuten).
The Script Concordance methodology is based on the cognitive theory that clinical expertise develops by the development and use of "scripts". In practice this theory assumes that clinicians sort, re-sort or reject the likelihood of a diagnosis and the appropriateness of a management strategy as each new piece of information is acquired for a particular clinical case.
The authors have developed and implemented assessments in Radiology, Surgery and Gynecology based on the clinical judgement of a group of experts in each field who are assumed to have many well developed "scripts". Each group of experts are asked to respond to a clinical vignette and rank (from negative 2 through neutral to positive 2) how specific additional pieces of information (items) would influence their thinking about a defined diagnostic or management strategy related to the case described. Because not all the experts give each item the same rank each is assigned a numerical "weight" of 0 to 1which reflects expert opinion. When trainees respond to the same items for each vignette their choices are scored and the total score reflects their level of concordance with the experts. Thus the "Script Concordance Test" (SCT)!
The radiology and gynecology assessments, which had 48 and 50 items respectively, had reliabilities (coefficient alpha) of 0.8. The surgery assessment, with only 26 items, had a reliability of 0.54. The authors conclude that this type of assessment requires 50 – 60 scoreable items to achieve acceptable reliabilities. They found indication of test validity in that the trend was for test scores to increase with level of training, with faculty scoring high, residents intermediate and students low.
Comment:
This is an interesting and promising potential methodology for our testing armamentarium because it looks at "real world" clinical knowledge using a pen and paper format that can be machine scored. It avoids the testing of "trivial" knowledge which can plague MCQ tests and seems to avoid the "intermediate" effect of other competence testing whereby experienced clinicians may have paradoxically lower scores than less experienced clinicians. Before the SCT can become widely accepted, however, more development

and testing is needed to see if these results are reproducible. If the SCT method does hold up to scrutiny it is interesting to speculate how it could be incorporated into clinical skills assessment of students. Maybe the SCT used in conjunction with standardized patient (SP) testing, which is the best method to assess interpersonal and communication skills but which has some psychometric problems with assessment of clinical functioning and reasoning, might yield a more comprehensive picture of clinical ability than SP testing alone.
I wonder if our COMSEP colleagues from Quebec and Montreal have had experience with this test and if the Evaluation Task Force would be interested in discussing the SCT at the COMSEP meeting? We might even want to think about undertaking development and piloting of a pediatric version. (Lindsay Lane, MD)

6. Student Perspectives on Primary Care Preceptorships: Enhancing the Learning Environment. Fernald D, et al. ***Teaching and Learning in Medicine 13 (1), 13-20***

This study has interesting implications for how to structure any outpatient primary care clinical experience. It represents the opinions of three years worth of students at the University of Colorado (of course if they are anything like our own Robin Deterding and Carol Kamen, they are obviously a much smarter than average group). It seems that students value active teaching (as opposed to - observing), active learning (its terrific that they identify taking the initiative to figure out what and how to learn from clinical experiences – rather than being spoon fed – as desirable) and a supportive environment (they value any and all relationships – where someone knows them personally – the Rich Sarkin point that we should get to know at least something personal about each learner comes to life here) as the key elements. This study also offers insight into how focus groups and qualitative research can be done.
How variable are the outpatient preceptor experiences your students get? Perhaps this kind of data can help your preceptors commit to at least some behaviors that make things active and supportive. Do you think it might help the students see the importance of taking on an active learner role?(Steve Miller, MD)

7. Evaluating a Clerkship Curriculum. DaRosa D. et al. ***Teaching and Learning in Medicine 13 (1), 21-26***

This study is a great model for evaluating the relevance of any curriculum. Polling graduates to identify conditions and procedures that are either frequently or seldom seen and either frequently or seldom referred, allows us to figure out what the core knowledge and skills might be – especially in a time limited clerkship. It also provides a way for faculty to take ownership of the curriculum and opens up opportunities for change and recommitment.
What would you include as the core – frequently seen/seldom referred, or seldom seen and frequently referred? I'd favor these two over seldom seen/seldom referred and even frequently seen/frequently referred – after all – the first two are the dangerous to miss and most common/relevant – for the generalist. I wonder if we should validate the COMSEP curriculum in a similar manner. (Steve Miller, MD)

8. Measuring Critical

Thinking. Kamen C. et al. (including Deterding R.) ***Teaching and Learning in Medicine 13 (1), 27-35***

No – I didn't just choose this to publicize the great work of our COMSEP colleagues from the distinguished state of Colorado – or to get them to invite me to the Rockies – rather, because its an important study in unlocking the secrets and nuances of measuring and possibly assessing critical thinking. There is a terrific discussion – with great references – on the distinction between critical thinking and problem solving, critical thinking and self directed learning and between critical thinking and creative thinking. There is also reference to the importance of reflective thought – an important component of some of the literature on humanism and professionalism – (including work by COMSEP members like Virginia Randle and Steve Miller/Rich Sarkin – I put this in to continue the tradition of shameless self serving comments). Finally, this is a great reference for anyone who wishes to gain insight into the rigors of qualitative research.
This paper gives us a tool for assessing whether our approaches to teaching promote more or less critical thinking than alternative approaches. How might you apply it to assessing new technologies? (Steve Miller, MD)

9. Strategic Planning in Medical Education. Gordon J et al. ***Medical Education 2000;34:841-850***

This is a comprehensive report on how to enhance the learning environment for students in clinical settings – which is our bread and butter. It identifies four key questions we need to answer for ourselves. How do we: 1) make sure that all the teachers understand the purpose and process of learning in the clinical realm, 2) equip students with survival skills as they enter this foreign country, 3) make the best use of each learning environment and 4) make the best use of informatics/technology in order to enhance efficiency. This could be a checklist for us as clerkship directors. I'm especially interested on how we equip our students with clinical survival skills.
How do you maximize use of information technology and what survival skills do you provide your students with? I'd love to see a list on the COMSEP listserve – I'm offering a prize for the best survival tip for medical students in clinical settings. (Steve Miller, MD)

10. 'Really Good Stuff': Reports of new ideas in medical education
Edited by M. Brownell Anderson - Published in Medical Education 2000; 34: 947- 958
This is an annual, peer-reviewed, collection of reports on innovative approaches to medical education.
It takes time and energy to complete that final published paper and I think many of you will be interested in considering publishing in the 'Really Good Stuff' section of the journal *Medical Education*. *Medical Education*, is celebrating its 35th year and is one of the oldest international journals of Medical Education. In the past decade the impact factor of the journal (a figure that reflects citation of papers published in the journal) has risen considerably.
'Really Good Stuff ' is a collection of brief descriptions (500 words maximum) of new approaches to medical education. Each report is organized into four sections, the context and setting; why the idea or change was necessary; what was done and evaluation of the results or impact. There are no tables, figures or

references allowed. The closing date for the next submission is May 1, 2001 with publication planned for November 2001. Guidelines are available by e-mail:
and can be viewed at the journal website:
. Like most journals, *Medical Education* receives many more papers than can be published. Many of these are descriptions of new ideas in curriculum design, teaching practice assessment or evaluation. As the journal wants to publish more papers in these categories, a regular November section will be 'Really Good Stuff'. All papers will be peer-reviewed. The papers will be evaluated based on the soundness of the educational approach described, the originality of the approach, the nature of the evaluation process planned for the program and the significance of the report to educational innovations. There are many COMSEP Members, who are undertaking innovative programs at their school that may want to consider submitting a publication. The timing is good as research papers, posters and workshops will be given at the March COMSEP. This would, therefore, be a great lead into a final paper. (Kim Blake - kblake@is.dal.ca)

Finally, from the "editor's corner", a little bit of humor, to closeout this issue of the Pediatric Educator.

"Passing through Third Year"
A guide for Wary Travelers
By Anne Eva Ricks

Communication is a major problem for medical students. For instance, when the chief resident in surgery say, "Take those bloods down to the lab as soon as possible," he means "*Run* them down *now*." Or when the 2nd year resident on medicine says, do we have an EKG on Mr. Morris?" he means," Go do an EKG on Mr. Morris, interpret it, and bring it back to me—before attending rounds."

Of course, the average medical student is reasonably bright and will pick up these nuances throughout the third year, with only a few major embarrassing and ego-shattering incidents.

But the following phrases, and their meanings might be helpful:

1. "**You have to learn to do this sometime.**"

This generally refers to a menial piece of scut-work that is important only because completion of medical school is predicated on its accomplishment, and not because of any intrinsic medical value; i.e., disimpacting a 101-year-old nursing home resident who has been frozen in a comatose fetal position since the Truman administration, or starting an I.V. in an ex-heroin addict who quit the habit because *he* couldn't find any more veins.

2. "**Everyone has blood.**"

Most frequent comment made by intern to third-year medical student after unsuccessful attempts at phlebotomy. Statement is generally made in patients' room, where student is surrounded by syringes, 4 x 4s, tourniquet, wrappers, tubes, lab slips, and at least seven used needles and six blown veins on one irate patient.

3. "**What are you going to specialize in, psychiatry**?"

This is a flashing red warning sign if said to a medical student by anyone other than a psychiatrist. If a surgeon says it, he thinks your nuts, or caught you actually talking to a patient. If a medicine doctor says it, he thinks your lazy. If an ob/gyn doctor says it, he simply noticed that you fainted at your first

screaming-through-the-E.R.-door-with-a-baby-between-the-legs-and-2,000 cc-blood-loss (mostly on your clothing) delivery.

4. **"No, I'm not a nurse."**

Most frequent statement uttered by women residents and medical students. Explaining that you are the Nobel Laureate in endocrinology or the TV repair lady will fall on deaf ears. No matter what you tell the patient hollering "Nurse! Nurse!" at you on rounds, he will then say, "Well, anyway, whatever you are, my bedpan needs emptying."

5. **"Maybe it's not too late to go to law school."**

Frequently used by students, residents, and attendings alike. Most often heard during disasters and when icky unidentified things are discovered on one's clothing.

6. **"Medicine is an art, not a science."**

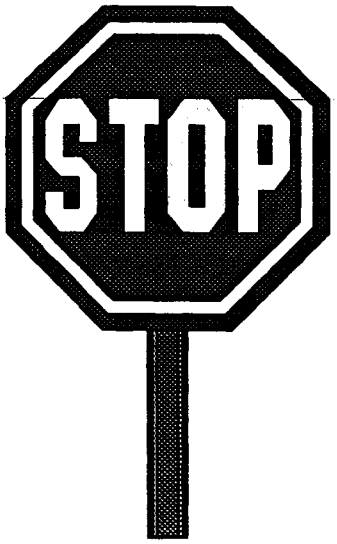
Doubles as a phrase to be used with patients, especially when something has gone wrong, is about to go wrong, or is wrong without medical solution. Also used by out-of-date attendings who haven't kept up their biochemistry and pharmacology and wish to stifle upstart residents who threaten to expose their knowledge deficit.

7. **"I can't do it. I'm too tired. This is disgusting"**

No.No.No. These phrases do not exist for the medical student nor the resident. They are not in their vocabulary. Besides, even if you are really, honestly, too exhausted to do something, they're going to make you do it anyway. Be it holding retractors for a renal transplant from 3 a.m. to 7 a.m. or completely working up your seventh E.R. admission with diabetes, renal failure, schizophrenia, and a medical record that comes up Volume 6 of 7 (but 7 is missing). Since your going to do it anyway, save your energy for the task at hand instead of wasting it on futile protestation.

So on the wards, keep alert for the difference between what is said and what is meant. Sure it's scary to be in the hospitals without any real sense of what you are supposed to be doing or how you should be doing it, but it's really not that bad an experience. It'll only hurt a little. Really.

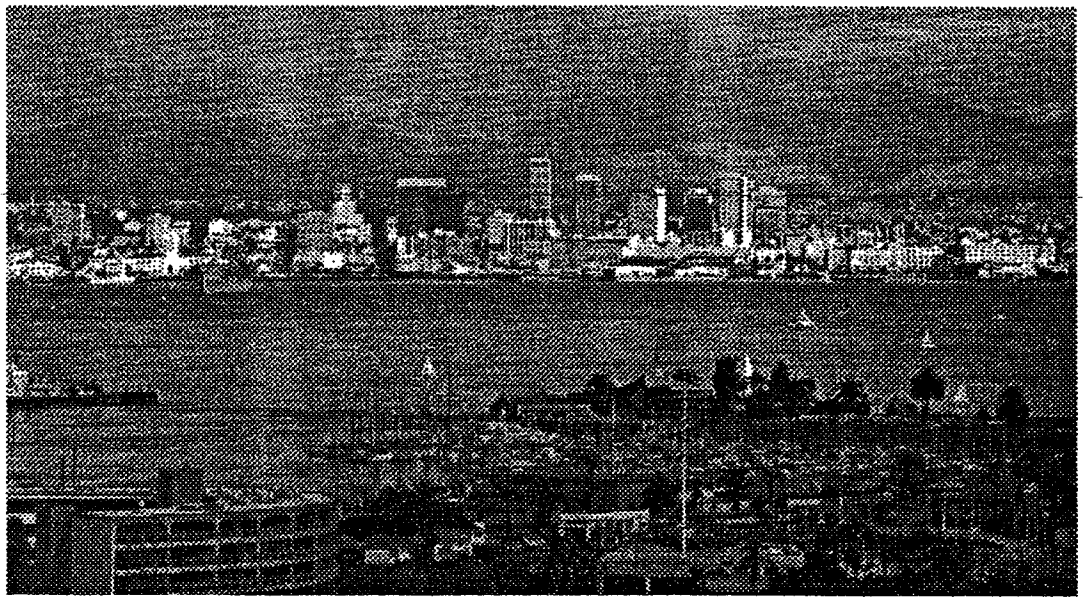
Taken from: The New Physician, 1982 31(8):16-19. Appeared in The Best of Medical Humor; Howard J. Bennett, MD, 1991



Don't forget to register NOW for the combined AMSPDC/ COMSEP Meeting, March 9-12, 2001 San Diego, CA

In closing, I would like to sincerely thank Richard Sarkin. Without his "strong-arm" tactics...I mean his tremendous influence, I would never be able to put the *Educator* together. G.F.

San Diego, California



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