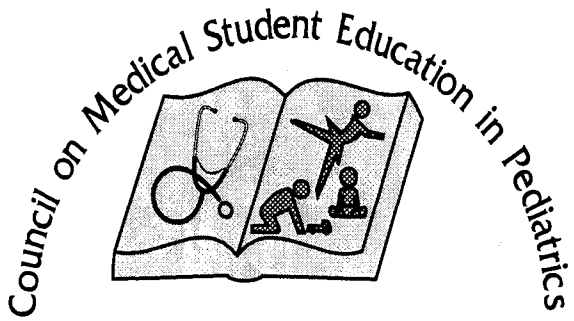
The Pediatric Educator



Volume 9 Issue 1 **Summer 2002**

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

President's Column

Bruce Morgenstern

I was warned about how hard it can be to be COMSEP president, but no one warned me how tough it is to write this column. For those of you who have been COMSEP members through a number of presidents, I apologize for the redundancy. If you're new to COMSEP, you may not read another column like this for 2 years, when Steve Miller has to do this. (Steve, a word of advice – start working on this now!). So, here's the redundant part: I am deeply honored to take the position of president of COMSEP. I am humbled to follow in the footsteps of the accomplished educators and inspiring leaders who have preceded me. I hope to do them proud; I hope to do you proud as well.

If you are new to COMSEP, and there's usually around 20 or so of you a year, welcome! I am willing to bet that you will come to love this organization as much as us "senior" members. The group is friendly, caring, giving and enthusiastic. Many view the annual meeting as the "fix" they need for the rejuvenation and motivation to keep on moving. You may, if you're a new clerkship director, have realized that his job is fun, but it's also challenging and hard work. You will learn to rely on your COMSEP colleagues, using personal contacts, the Web site and the listserv, to avoid reinventing the wheel. Many of us have tried things, tweaked things, and tinkered over the years. Sometimes we did it thoughtfully and published the results, other times we just accrued experience. We are all willing to share. Feel free to ask. If you are new and you have not been getting an occasional message from the COMSEP listserv, you need to let either Jean Bartholomew or me know. Jean, as an aside, is the glue that holds COMSEP together and the fuel that keeps the COMSEP engine idling (the president and the task force leaders are useful for sprints, but we are not good at idle speeds, our engines die without Jean). Look on the Web site to find ways to contact us. If you have tried to get into the COMSEP community at the web site and have not succeeded, let either Robin Deterding or me know. We'll make it happen.

So what's the plan for the rest of 2002? Well, stuff is always happening. There are 5 task forces, and they have some definite goals. You will see the 2002-2003 version of the Curriculum, from the Curriculum Task Force, on the Web site, in the community section, in the library, which is a tab at the top once you get into the community part of the site. The Learning Technology Task Force is still trying to learn all the capabilities of the site, and will send out information as it becomes available (for example, I need to get the list moved to the site, which will allow attachments to be sent out by this list (viruses too, I suppose). The Research Task Force has infiltrated the other task forces, and has issued the call for abstracts that is a part of this edition of the Educator. The Faculty Development Task Force is planning several workshops targeted at clerkship directors with different needs for the 2003 annual meeting, and is heading up the Journal Club that appears late in this issue. The Evaluation Task Force is working on establishing some test banks for general use.

How do you become a member of a Task Force, you might ask? Simple – just join. If you read something that intrigues you in this issue, contact the author/task force leader and ask how you can help. Believe me, we all love volunteers. At the annual meetings, you will hear about the Task Force sessions, and can simply attend the one of your choice.

Finally, COMSEP is in its second decade of existence. We've done some wonderful things in our early childhood, and it's time to plan for our adolescence. For that reason, I am trying to spearhead a strategic planning process that will play out over this year. Many of you have already been kind enough to complete the survey that I sent out a few months ago. All of the past presidents have offered their input. We will get the Executive Committee to help us put out a document that will try to address: What is COMSEP? What should COMSEP do for you the clerkship director? What should COMSEP do for the students? Where does COMSEP fit in the arena of Pediatric organizations? Other educational organizations? Should COMSEP grow? If you have thoughts and have not sent them to me, please do by the end of August.

In education, feedback is paramount. For this organization, I think that the same tenet applies. We need to hear from you. Calls, e-mails, letters. Let us know what you think. Offer to help. COMSEP thrives on volunteerism, and I really need all the help I can get.

Hope to hear from you soon.

Bruce

COMSEP Colorado 2003! "Achieving Excellence while Maintaining Balance"

Remember to mark your calendars for another outstanding COMSEP meeting on April 3-6th, 2003. Our theme "Achieving Excellence while Maintaining Balance" will focus on how to achieve excellence in medical education but also to think about other aspects of life that give us balance. Topics related to excellence in education are assured. We are fortunate to host Dr. George Bordage an internationally recognized expert in medical education scholarship and diagnostic reasoning as our plenary speaker. Of course, the great workshops and research that COMSEP members present are sure to be consistent with this theme of excellence. Please make it a point to share your best stuff with all of us in 2003. We also have little activities planned to get you thinking about balance. The

beautiful setting of the International Omni resort nestled next to the Boulder Flatirons is just the place! Stay tuned to the COMSEP website for updates about the meeting and ideas for a little balance before the meeting too. WE CAN'T WAIT TO SEE EVERYONE IN APRIL! Robin Deterding and Shale Wong your Colorado hosts.

Now some insight from a future Pediatrician and hopefully COMSEP member.

Reflections from a 2nd Year Pediatric Resident Who Attended the 2002 COMSEP Meeting

It was a privilege for me to attend the 2002 COMSEP conference. I learned about this conference over a year ago when Dr. Sarkin visited the University of Wisconsin-Madison. At the time I knew I was interested in career options involving medical education. Dr. Sarkin and Dr. Pat Kokotailo both encouraged my interest and suggested that I attend this year's COMSEP conference. There are several aspects of the conference that I found quite remarkable. First was the friendly, supportive, and collegiate atmosphere. Newcomers, myself included, were genuinely made to feel welcome. Another striking aspect for me was learning about the shear volume of opportunities, research, and information that exists in the area of pediatric medical education. I loved learning about what different programs were doing in their new curricula and their research projects. I was excited by the breadth and depth of opportunities that exist for those interested in medical education. A third aspect of the conference that impressed me was the commitment to making the conference fun. Everyone seemed to greatly enjoy themselves. The few conferences that I have attended previously have had more of a serious or businesslike feeling. This one had an air of merriment about it.

I was the sole resident participant at the conference. I was also a relative outsider in that I was at a conference intended for clerkship directors, though I am not a clerkship director. However, I feel that I gained a great deal by attending the conference. Dr. Sarkin asked me to comment on whether I thought other residents or medical students would benefit from attending the COMSEP conference in the future. I feel that residents who are interested in pursuing medical education in the future *would* benefit from attending this conference. The COMSEP conference opened my eyes to the opportunities available for a career involving medical education. I was able to obtain a glimpse of what I would like to work towards for my own personal future. Residents who share this interest in education would enjoy and learn from this conference.

A second group of residents that would benefit from attending the COMSEP conference is current or future Pediatric Chief Residents. As a future Chief Resident I know that my job will involve both administration and education aspects of the residency program. I, and other future chiefs, would be interested in learning how to better educate residents in their teaching of medical students.Additionally, Chief Residents are often in the unique position of having the power or ability to create conferences for residents and faculty. COMSEP could help Chief Residents design conferences, perhaps similar to faculty development work-shops, on topics such as evaluating and grading, giving feedback, and teaching students.

Should COMSEP open up the conference to all residents and medical students, or push for

resident and student attendance? I expected to feel that I would walk away from this conference with that as a recommendation. However, I don't know that opening up the conference to all residents or medical students is the appropriate direction for COMSEP. Simply put, the workshops in COMSEP are intended for clerkship directors. I noted a level of sophistication in the workshops that residents, myself included, do not possess. For example, I think that residents might be interested in learning about research opportunities, writing grants, or getting published in journals. I was interested in these topics and attended the COMSEP workshops on grant writing and writing for publication. Though I learned a great deal from the workshops and the group discussions that occurred during the workshops, I knew that the other workshop attendees were generally well versed in these topics and came to the workshops to improve their skills. Most residents would benefit more from learning those skills in the first place. To tailor these workshops to the resident or student level would involve having workshops on Beginning Grant Writing, or Writing for Publication 101. I do not feel that COMSEP is intended for that purpose. I realize there were many other workshops that one could attend at the conference. Some of those would likely be appropriate for resident or student attendance. However, many of them were above the level of the average student or resident. This is by no means a criticism, I think it is more of a reflection of the purpose of COMSEP: to create a conference intended to educate and improve current (and possibly future?) clerkship directors.

Lastly, I cannot help but to put in a comment from the resident level. Not every resident likes to teach, but most do. Most residents would love to hear how to teach better. In my almost two years of residency I have had a lot of feedback on how I care for patients, but little feedback from attendings on how I teach students. If your resident on service teaches well, let them know. Chances are, they'll teach more. Teach us, and then use us to keep the teaching going.

Thank you again for the wonderful experience at COMSEP.

Megan Moreno, MD
2nd Year Pediatric Resident

Some brief but important announcements

Check out the COMSEP Website
http://www.comsep.org/index.htm
See the announcements, new 6/02 Clinical problem sets, 6/02 revised COMSEP curriculum, more information about COMSEP 2003 in Colorado, on-line versions of the information published in the Educator and participate in an on-line discussion of Journal club!

Revision of the APA Educational Guidelines
Submitted by Richard Sarkin

The 1996 APA Educational Guidelines for Residency Training in General Pediatrics are in the process of being revised. The new guidelines will reflect changes in the science and practice of pediatrics, as well as a much more flexible and adaptable online version. In addition, the new guidelines will emphasize a competency-based curriculum. Diane Kittredge from Dartmouth is the Project Director. Several COMSEP members are involved in this project. The 1996 edition of these guidelines is currently available at the APA website: www.ambpeds.org

Pediatric Education Steering Committee
Submitted by Richard Sarkin

COMSEP is now a member of the Pediatric Education Steering Committee (PESC). I am currently COMSEP's representative to the PESC. Other member organizations of the PESC include the APA, AAP, ABP, APS, AMSPDC, APPD and SPR. Richard Berhman, who most recently was the Senior Vice-President of the Lucile Packard Foundation for Children's Health, is chairing the PESC. The PESC has been charged with implementing the recommendations of the FOPE II Task Force.

I attended the most recent PESC meeting on May 4th in Baltimore. The major topic of discussion of this meeting was the "Proposed Revised Requirements for Sub-specialty Training" that were developed by the American Board of Pediatrics (www.abp.org/frnews.htm). A meeting sponsored by the PESC is being planned for October in Boston to discuss these proposed revised requirements.

Report from the AAP COPE Committee – 2002
Submitted by Patricia Kokotailo, MD, MPH, COMSEP representative to COPE

The American Academy of Pediatrics (AAP) Committee on Pediatric Education (COPE) met on July 14-15, 2002, at the AAP Headquarters in Elk Grove Village, Illinois. The membership of this committee includes representatives from all major US and Canadian pediatric associations with a focus on pediatric education, and representatives from the AAP Department of Education divisions as well as committees and journals. The purpose of the COPE committee is to act as a think tank within the AAP for discussion, consensus building and collaboration on emerging issues facing pediatric education. The 2002-3 goals and objectives for the committee include serving as a resource and clearing house for all COPE constituent societies on information and programs related to the educational aspects of cultural competence and international pediatrics; developing a draft proposal that will identify and evaluate the effectiveness of the elements of a continuing medical education (CME) home and the resources and strategies needed for achieving this; advancing the concept of lifelong learning especially in accomplishing the FOPE II (Future of Pediatric Education II) recommendations of the AAP and establishing an individualized CME plan for residents that will anticipate future practice needs; and supporting the AAP initiatives in international pediatrics.

Reports were given from committee members emphasizing their organizations' activities, especially in regard to the committee goals and objectives. I reported on the revision of the COMSEP national medical student curriculum, the updated COMSEP website, and our continuing association with the Association of Pediatric Program Directors (APPD), especially in our attempt to establish a collaborative research program to study the curricula and assessment tools we must create to implement a competency-based system of education for medical students and residents. Major topics of discussion for the committee included the American Board of Pediatrics (APB) "Proposed Revised Requirements for Subspecialty Training" regarding the flexibility of training pathways, establishment of an Accelerated Research Pathway, discontinuation of a research requirement, and content specifications for examination. Please see the entire ABP document at
http://www.apb.org/frtrain.htm

In this discussion, I added that

an issue pertinent to students was the ability for them to have an honest evaluation in the residency application process if they were leave a program early due to increased fellowship flexibility. The discontinuation of a research requirement was a hot topic, and many of us agreed that elimination of a required research publication could be reasonable, but not involvement in research (especially important to less researched fields such as adolescent medicine and developmental pediatrics). Inclusion of master educator and master clinician pathways, not only bench research, was discussed. Please forward further comments on this proposal to me at

pkkokota@facstaff.wisc.edu

and I will compile them for the ABP. Discussion of reduced resident duty hours led to a letter being generated from the committee in support of the proposal from the AAP Resident Section. J1 visa legislation and international graduates in the workforce also generated major discussion. An excellent legislative summary was prepared by Karen Hendricks, JD, from the AAP Department of Federal Affairs and will be posted on the COMSEP website.

Alliance for Clinical Education (ACE)

The Alliance for Clinical Education (ACE) was formed in 1992 to enhance clinical instruction of medical students. ACE is the "umbrella" organization representing seven professional medical clerkship organizations: Association for Surgical Education (ASE), Association of Directors of Medical Student Education in Psychiatry (ADMSEP), Association of Professors of Gynecology and Obstetrics (APGO), Clerkship Directors in Internal Medicine (CDIM), Consortium of Neurology Clerkship Directors (CNCD), Council on Medical Student Education in Pediatrics (COMSEP), and the Society of Teachers of Family Medicine (STFM)

ACE's mission is to foster collaboration across specialties to promote excellence in clinical education of medical students. ACE works in collaboration with the Association of American Medical Colleges (AAMC) and its constituencies to develop innovative, integrated, and cost effective models for the clinical education of medical students.

Recent ACE activities include a continuing effort to collaborate with the AAMC as it addresses a current major interest, the clinical education of medical students. The role of ACE in this activity is not yet clear, but ACE representatives are collaborating to move forward with a common front.

ACE is also creating a document tentatively entitled "Expectations of and for Clerkship Directors." The working title makes the content self-evident: the qualifications, expectations, and resources to ensure that the clerkship director succeeds both executing a quality clerkship and advancing his or her career. The manuscript is targeted at deans and department chairs, but also provides a very clear guide for the clerkship director. It is to be approved by each organization's executive board and then will be submitted for publication.

Members from ACE's constituent groups attended the APGO Interdisciplinary Women's Health Education Retreat 2000. Each organization has also helped to develop *Women's Health Care Competencies for Medical Students*, a direct outcome of that retreat. As soon as these are finalized, they will be widely distributed.

This November, at the AAMC Annual Meeting in San Francisco, ACE will be presenting a small group workshop titled, "Inter-Clerkship Collaboration: Enhancing Core Competencies" (Tuesday, Nov. 12, 10:00am – 11:30am). Presenters include Diane Magrane, MD, Associate Dean for Medical Education and Professor, Department of Ob-Gyn, University of Vermont College of Medicine representing APGO; Lynn Cleary, MD, Associate Dean for Curriculum, SUNY Upstate Medical University College of Medicine representing CDIM; and Fred McCurdy, MD, MPH, MBA, FAAP, Associate Chair for Pediatric Education and Professor, Department of Pediatrics, University of Nebraska Medical Center representing COMSEP.

Bruce Morgenstern, MD

The following report is a summary of last year's SIG meeting and the proposed agenda for next year's meeting.

SPECIAL INTEREST GROUP FOR MEDICAL STUDENT EDUCATION: Summary of 2002 Annual Meeting and Proposed Agenda for 2002-2003.

This summary will have four sections.

1) Overview of SIG Mission and Overall Goals
2) Summary of Annual Meeting
3) Summary of current education initiatives – of interest to all residents and faculty who teach at any level – including review of faculty development opportunities and other important organizations and web sites
4) Proposed agenda for the upcoming year

Please email me with input on the proposed agenda for the coming year. (Steve Miller at szm1@columbia.edu)

1. SIG Mission and Goals - Overall

- To create a home for medical education in Pediatrics
- To disseminate information for faculty development and career development of members
- To partner with other SIGs to enhance the approach to education and training, including seeking out partnerships with Residency Program Directors, Faculty Development, Informatics, Office Based Practitioners, Hospitalists, Injury Prevention, Advocacy, Continuity Clinic, and Emergency Medicine – to name a few representative examples.

Objectives:

- To describe the purpose of the SIG
- To identify career development opportunities
- To describe faculty development opportunities
- To describe new tools for education
- To identify priorities in education
- To partner with other SIGs to promote education

2. Summary of 2002 SIG Meeting

Title: Competency Based Evaluation: Using the Tools and Searching for Collaboration

The meeting focused on testing real time evaluation and feedback tools for medical students and residents. Over 100 people participated, including many senior educators and many first time attendees (about 15% of the

group). As usual, the advancement of our attendees was a primary goal – and having so many experienced people – interacting with new members – was a critical outcome of the meeting. We were also pleased to see an international presence, with attendees from New Zealand and Lebanon.

The meeting goals were:

- To define competency based evaluation
- To demonstrate real time competency based evaluation tools
- To practice using these tools
- To identify the strengths and weaknesses of existing tools
- To identify strategies for successful implementation
- To define further work needed to develop better tools

The Agenda was:
8:00AM-8:15AM - Review Posters

8:15-8:30AM - SIG Intro: What's new in medical education? - Steve Miller

8:30-9:00AM - Competencies and Observation Based Evaluation – Steve Miller, Bill Raszka

9:00-9:20AM - Review of Real Time Tools: Jon Fliegel (BSO), Lindsay Lane (SCO), Sherilyn mith (CEX), Steve Miller, MD (Kalamazoo Checklist)

9:20-10:20AM - Trying Out the Tool: Scott Jones

10:20–10:40AM: Large Group Discussion: What were the strengths and weaknesses of the tools you used? What are the challenges to implementation?

10:40–11:00AM: Wrap up - Discussion of next year's SIG: How should we collaborate with Faculty Development, APPD, STFM, COMSEP – in this work on Competency-Based Evaluation? Can we develop a more refined toolbox to the current ACGME toolbox? Next Year's Priorities

Posters:

1. "Promoting Humanism in Medicine." Steve Miller,MD and Richard Sarkin, MD

2. "Creating a Local Developmental-Behavioral Pediatrics Referral Directory in Residency Training." Samuel Zinner, MD

3. "Teaching Culturally Effective Health Care to Third-Year Medical Students: A Needs Assessment." Caroline R. Paul MD, Jeffrey M. Devries, MD, MPH, Jonathan E. Fliegel, MD

4."Evaluating Competencies Using Student-Generated Professional Development Plans: A Pilot Study." Rose Marie Thomas*,RN,MS,CCRN, PhillipFulkerson,** MD, Karen Phelan,*** MD, Michael Potts,***, MD
Departments of Surgery*, Academic Affairs / Medicine,**&Pediatrics** University of Illinois College of Medicine at Rockford, Rockford, IL

5. "A Web-based OSCE station to measure Competence in EBM skills in Medical Students." Jonathan Fliegel, MD, John Frohna, Larry Gruppen, and Rajesh Mangrulkar
University of Michigan

6. "Teaching and Evaluating Advocacy Skills" Janice Hanson et al.

3. Education Organizations and Current Initiatives

APA Student Education SIG

Steve Miller, MD, SIG Chair, Children's Hospital of New

York - Presbyterian / Columbia University
Broadway and 168th Street
BH5N-518
Phone: 212-305-6076
e-mail:szml@columbia.edu
Annual Meeting: 2003, Seattle, Washington

1. STFM, IM Collaboration
2. Competency based check list for physical examination, T. Murphy and Sherilyn Smith, MD
3. Web site being set up – for APA members only

APA:
Annual Meeting: April 2003 in Seattle
1. Committee on Education: Michelle Barrett, MD
   a) focused call for workshops each year
   b) review abstracts
   c)Residency Guidelines Revision: Ken Roberts, MD, Diane Kittridge, MD
2. Poster displays prior to meeting
3. listserv: APA-NET@ambpeds.org
4. On-line: www.ambpeds.org
5. APA JOURNAL: Larrie Greenberg, MD, Ben Siegel, MD
6. Faculty Development SIG: Charlie Gaebler, MD, Ron Marino, MD

COMSEP: Council on Medical Student Education in Pediatrics
Bruce Morgenstern, MD - President
Richard Sarkin, MD – Past President
1. Annual meeting:April 3-6, 2003: Broomfield, CO
2. Task Forces: Curriculum; Evaluation; Faculty Development; Research; Technology
3. Web site: COMSEP.org
4. listserv: comsep@ mayo.edu (mgr: bmorgenstern@mayo.edu)
5. Curriculum for Core Clerkship in Pediatrics
6. Physical Examination Video
7. Journal Review

AAMC: Association of American Medical Colleges
www.aamc.org
November 8-14, 2002: meeting in San Francisco- Research in Medical Education

Group on Educational Affairs (GEA)
Includes section on Student Education, Regional GEA meetings: NE, SE, Central, Western

4. Proposed Agenda for 2002-2003
   - Workgroup to develop competency based checklist for evaluating the physical examination: T. Murphy and Sherilyn Smith, MD Conveners.
   - Develop agenda for next annual meeting. Currently, the top choices are to refine competency-based evaluation for professionalism and humanism, sharing novel methods of instruction, using technology to enhance education, providing effective feedback about humanism and reasoning, and effective teaching in the office setting.

Email your suggestions to me at:
szml@columbia.edu

   - New members of the working group were identified as well – including many junior attendees – reinforcing our mission to promote advancement of our members.

Respectfully submitted:

APA Student Education SIG:
Working Group:
Steve Miller (Chair)
Lindsay Lane, Bill Raszka (Associate Chairs)
Jon Fliegel
Jamie Hoffman - Rosenfeld
Lyuba Konopasek
Harold Bland
Scott Jones

Maria Marquez
Mike Barone
Sherilyn Smith
Jeff Longacre
Christine Johnson
Paula Algranati
Roger Berkow
Mike Potts
Jenn Koestler
Karen Phelan
Janet Fischel
Leslie Quinn
Jan Hanson

New Members for 2002-2003: Karen Marcdante, ShaleWong, Vanthaya Gan, Sandy Sanguino, Nasreen Talib, Antionette Spotto – Cannons, Terrance Murphy, Caroline Paul, Carol Miller, Marissa Brett - Fleegler

(Another "brief" submission by Steve Miller!)

Task Force Reports

Faculty Development Task Force COMSEP 2002 Minutes

The Faculty Development Task Force met on March 15 and 17 at the 2002 COMSEP meeting in Nashville. We reviewed the status of projects that were discussed at last year's meeting, as well as ongoing projects and plans for future activities, including next year's meeting in Denver. As is the tradition of this group, there was active and enthusiastic discussion, and many ideas were offered.

Journal Review. Steve Miller led the discussion of the current journal review process, and solicited suggestions for improvement. Access to educational journals at some institutions is a problem, even though some do offer "on line" subscriptions. The "time line" from requests for reviews to publication date may be too short and could be extended. The possibility of having COMSEP peers review the reviews prior to final editing and publication was discussed, as was the possibility of having "thematic reviews" (several articles related to the same topic, reviewed together). This process may lend itself to multi-authored reviews. Larrie Greenberg mentioned the possibility of adding brief reviews of books to the activity, and Larrie has been named the Book Editor. Potential workshop topics related to the process of reviewing scholarly articles and "getting into the loop" as a reviewer for other journals were discussed. Volunteers for the upcoming year were solicited, and will be contacted by Steve Miller. Janet Fischel. Helen Loeser, and Lindsay Lane will join Steve on the Editorial Board for this activity. Bruce Morgenstern will be the "point person" for obtaining copies of articles for reviewers. A forum on the new website will be placed to facilitate communication among reviewers.

Workshop "Pairing". The idea of "pairing" workshop presenters, which initiated in this task force, has continued to be successful, and will be encouraged in future meetings. There were 54 individuals involved in the presentation of the 20 workshops at this year's meeting.

Mentoring Project: The Mentoring Project was reviewed, and was felt that it was a worthwhile activity. There was discussion regarding how to best identify new members or members interested in the mentoring activity.

"Meet the Experts" Lunch: The plans for the lunch session were reviewed before the luncheon on Friday. The lunch session went smoothly, and it was felt that this should be continued at future meetings.

Recurring Workshops: At the previous 2 meetings, the idea of having a group of core workshop topics that should be presented regularly was endorsed. Most of these topics were covered on the workshop program for this year, and it

was felt that "core" workshops should continue to be a part of each year's program. Topics which have been suggested as "core" topics included workshops (how to plan and conduct a workshop), promotion and portfolio development, the problem learner, evaluation, feedback,curriculum development, teaching methods, problem faculty, and leadership. It was felt that the "New Clerkship Directors" workshop should also continue to be an annual workshop.

Workshop topics: We discussed a number of potential topics for workshops at next year's meeting, in addition to the "core" topics mentioned above. These included evaluating scholarly articles in education, "getting in the loop" as a reviewer, educator's portfolios, continuing excellence/ avoiding burnout, time management, negotiation, "balance" between career and personal goals, conflict resolution/mediation, recruiting volunteer faculty, development of the Chief Resident as an educator, enhancing the interface between the residency program and medical student education, medical student teaching in the current economic environment, evaluation tools, teachable moments, and feedback. It was felt that workshops with similar themes should not be "grouped" on the same day, since this reduced the number of workshops related to a specific theme that could be attended. In addition to the New Clerkship Directors Workshop, another pre-conference workshop for mid-career clerkship directors which would focus on career development, perhaps including breakout sessions for individual mentoring, was also discussed.

COMSEP Website: The website offers opportunities for all of the task forces to expand their missions. Leslie Fall will serve as the Faculty Development Task Force's liaison to the Technology Task Force and the website.

Suggestions for workshop improvement: The process of workshop selection was discussed. It was suggested that the Research Task Force look into a process to evaluate our workshop activities and the effectiveness of the workshops.

Certificate Program: Fred McCurdy discussed the Education Leadership Management Certificate Program that is currently conducted by one of the regional education groups. There may be interest in our membership and by our colleagues in Pediatric education to participate in a similar activity organized through COMSEP and held in conjunction with the annual meeting. Fred will provide a website address which describes the program. The proposed "Career Development" pre-clinical workshop might serve as an introduction to this type of activity.

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

Respectfully submitted,

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

Evaluation Task Force Meeting
Friday, March 15, and
Sunday, March 17, 2002

TEST QUESTION BANK: 95/125 clerkships use the NBME shelf exam; some of these use their own exam as well. The group endorsed the idea of developing a bank of test questions. Several members volunteered to share their own questions or banks developed from a variety of sources. The group agreed to explore the possibility of

obtaining administrative support to store and sort/index questions (e.g. using keywords, topics). The question bank could be offered to the community on our web site. With a large number of questions, security would not be a major issue.

OSCE CASE BANK:
There are schools that would be willing to share SP cases. Some members of the group agreed to develop a template that would allow COMSEP members to submit cases in outline format. We will explore the possibility of creating an OSCE case bank on the COMSEP website that is sorted / indexed in the same way we proposed for the question bank i.e. using keywords or topics. Getting some administrative assistance for this process was suggested.

COMPETENCY BASED EVALUATION:
The mandate for competency-based language in curricula and competency-based evaluations (CBE) will undoubtedly trickle down from graduate medical education to medical schools. (Indeed the APA Medical Education SIG discussed CBE last year and will be addressing the same topic this year.)

The group reviewed the definition of a competency and the qualities of good evaluations. Several member schools have already rewritten curricula into competency-based language and incorporated either the ACGME (GME) or MSOP (UGME) competencies.

The group discussed doing more work in this area and which competency areas should be priorities. Professionalism and altruism were specifically mentioned in this context. Other ideas that were discussed were peer-evaluation and student portfolios.

It was also suggested that the group write a summary or chapter about competency based evaluation for the COMSEP website and /or curriculum.

The APPD has developed task forces similar to those in COMSEP. We plan to network with our counterparts in the APPD and hope to collaborate on projects related to competency-based evaluation.

Research Task Force

The Research Task Force had an active meeting at COMSEP. First, we discussed the topic of a small grants program ($500-$1000/award) to be available through COMSEP. We believe that awarding several of these to well-designed collaborative research projects will aid the growing amount of medical education research done by our members. It would provide start-up funding and be a method to encourage our members to collaborate.

We already plan to put a mentor list on the COMSEP website so investigators can obtain feedback as needed. The website will now also contain a collaboration section to put out ideas for such studies. This may aid cross-fertilization of ideas among members between out yearly meetings.

We would like to propose that Research & Scholarship in Medical Education would be an excellent theme for a future COMSEP meeting. It would allow members to obtain up-to-date information on selected topics in medical education and could provide workshops needed to perform the skills of research.

For next year, we suggest the following changes for research abstracts presentation. We would suggest that the four platform presentations be given after the Business section of the meeting, when most members are present, early in both the day and the

meeting. This will support the importance of continuing research and innovations in our field. Another suggestion would be to have 2-3 poster sessions in conjunction with a buffet or continental breakfast. We would like to group the poster session by theme; again to stimulate collaboration between investigators. Brief oral summaries of each poster (2-3 minutes) could orient the group to the posters being presented. An hour scheduled where individuals could meet privately with a mentor to discuss a project or their teaching portfolio would also be supportive and instructive.

Submitted by Cindy Christy

Learning Technology Task force (LTTF) Annual Meeting 2002 Report

The task force meeting in Nashville was well attended and productive. A major focus of the 2002 annual meeting was to launch the successful COMSEP website. To this end the LTTF supported a pre-conference workshop and discussion time within the meeting designed to get members acquainted with resources and features on the site. The task force felt strongly that on-going faculty development about the site needed to occur at the 2003 Colorado meeting as a workshop and / or as part of the new clerkship directors meeting.

Issues around technology faculty development for COMSEP members were also discussed. Workshops related to multimedia teaching material, as provided by Chris White and Bill Raszka, were felt to be important and should be continued. Chris Maloney expressed interest in developing a workshop for members focused on using technology to teach evidence-based medicine at the 2003 Colorado meeting. This idea was enthusiastically supported and a small working group met to carry this project forward. Members can look forward to another great slate of technology faculty development workshops from the LTTF in Colorado!

Research task force members discussed options for collaborative research in technology. Ideas to put up an area in the website discussion forum for those interested in collaborating on research projects was approved and completed. Brainstorming sessions focused on ways to scholarly evaluate activity on the website and discussion forum was encouraging but no conclusions were reached. There appears to be potential in this area for interested individuals. This discussion should be even more exciting in 2003 with data on the use of the website. Perhaps those interested can get an early start on the 2003 meeting in the discussion forum!

We also had our traditional time to share new ways technology is being used by members in teaching and learning. It is always exciting to hear what is happening!

Members participated in other task forces on the last day to see what other needs may exist that our LTTF could address.

We look forward to another exciting year in Denver as we gain more experience with technology and the website.

Submitted by Robin Deterding

And now, the much anticipated literature review

Pediatric Educator: Journal Review

Welcome to our eighth journal review. I'd like to acknowledge Karen 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 influences our practice. And finally, it gives us a chance to work together across our institutions to disseminate ideas. This is a great opportunity for everyone to participate, so let me know if you want to serve as a reviewer next year.

Please, e-mail me at

szm1@Columbia.edu

or through the COMSEP listserv with your comments. *(Steve Miller, MD)*

This also marks the first time that the Journal Review will be published simultaneously on the COMSEP website. I ask all of you to check it out on line – so we can document its impact. We hope that this Journal Review will have a scholarly impact – in disseminating new ideas about medical education and about how medical education research is conducted. So, answer our questions – on line.

Pediatric Educator Journal Review : Vol. 4, No. 8, July 2002

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Linda Tewksbury, MD

1. L J Miedzinski, P Davis, H Al-Shurafa , & J C Morrison
A Canadian Faculty Of Medicine And Dentistry's Survey of Career Development Needs.
Medical Education 2001; 35:890-900

Reviewer:
Bruce Morgenstern, MD

The objectives of this project were: to determine the perceived career development needs of a Faculty of Medicine and Dentistry's academic staff; to determine preferred modes and times of delivery for career development programs, and to determine whether gender, academic rank, or career track influenced perceived needs, preferred learning vehicles or preferred times of delivery. A 35 item piloted survey (Likert scale) was sent to 446 faculty at the University of Alberta Faculty of Medicine and Dentistry. 181 responses (41%) were analyzed.

The top 10 needs were (mean score in parentheses):

1. Effective writing of grants and publications (4· 12)
2. Personal organization and time management (3· 88)
3. Effective communication (oral and written) (3· 86)
4. Effective goal setting (personal/ professional) (3· 79)
5. Managing information/infor matics (3· 76)

6. Effective leadership skills(3· 73)
7. Managing a research program (3· 73)
8. Preparing for promotion (3· 71)
9. Managing stress (3· 70)
10. Change (adapting to and managing it) (3· 65)

Legislation influencing health practices, documenting one's clinical contributions understanding the role of an academic medical center, patient rights, professional liability, clinical practice guidelines, teaching in an ambulatory setting, ethical issues, preparing a curriculum vitae, and effective group teaching were all considered more important by clinical teachers than basic scientists. There were other differences that became apparent when the results were sorted by gender, marital status, or professional rank. All subgroups preferred to learn in short courses/workshops/ seminars, but there were many preferred times for the delivery of these courses, based upon gender, marital status, etc.

The authors note that "it was of some concern that those skills in the domain of education (effective group teaching, teaching in an ambulatory setting, tutoring in problem-based learning) were, generally speaking, ranked much lower," but this school has a fully subsidized teaching enhancement program in place, and perhaps the respondents felt that these opportunities were readily available.

The key points were felt to be:

1) Career development efforts should ideally focus on the perceived needs of adult learners.

2) Survey assessments of academic faculty can provide an indication of where initial career development efforts might begin.

3) Career development needs are variable over academic rank, gender and clinical versus basic science career tracks.

These results are not surprising. The authors and the journal were kind enough to submit the questionnaire with the paper, and one wonders if the structure of the survey was in fact responsible for the results. The questions seemed to have an order, and the teaching skills questions were toward the bottom. Perhaps the respondents had "used" up their high scores before they got to teaching needs. At any rate, the real message here is that you need to assess needs before you put forth a solution. The authors were also smart enough to assess the preferences for how and when the faculty wanted to get the information they felt they needed. The answer was clear in terms of the how, but the when was all over the map. **(Bruce Morgenstern, MD)**

This study has implications for the APA Faculty Development initiative to define a curriculum for faculty development. It also challenges us to define a similar curriculum in our Faculty Development Task Force – or perhaps – collaborate. Another methodology for this type of needs assessment is to have you faculty choose their top three choices and then set priorities accordingly.

What would your top three areas of faculty development be? (Steve Miller, MD)

2. Jozefowicz RF, Koeppen BM, et. al.,
The Quality of In-house Medical School Examinations.
Academic Medicine 2002;77:156-161.

Reviewer: Randy Rockney,

A total of 555 multiple choice questions gathered from nine

basic science examinations from three medical schools were subjected to quality assessment by three expert biomedical test developers. The three experts had extensive experience in reviewing and evaluating questions for the USMLE Steps 1 and 2. The questions were rated on a five point scale: 1= tested recall only and was technically flawed to 5= used a clinical or laboratory vignette, required reasoning to answer, and was free of technical flaws. The mean score for all questions was 2.39 $\pm$ 1.21. The 92 questions written by NBME-trained question writers had a mean score of 4.24 $\pm$ 0.85, and the 463 questions written by faculty without formal NBME training had a mean score of 2.03 $\pm$ 0.90 ($p<.01$). If a question did not involve a vignette, it was awarded a maximum score of 3.

The study shows that NBME-trained question writers tend to write questions that are more highly rated by NBME-trained question raters. This is the major flaw of the paper, a flaw that is fully acknowledged by the authors. The validity of the conclusions is thus contingent on how much faith one has in the question writing standards of the NBME. The point of the paper, however, is a good one. As stated by the authors: "A well-written examination reflects positively on a course. It demonstrates to the students that the course's director and faculty take pride in all aspects of the course." As pointed out by the authors, test items are often given little thought and no peer review before being used in a high stakes examination. Also, few persons in academic medicine are trained to write questions. Again, as stated by the authors: "Like many expectations for faculty in academic medicine, the assumption is that all possess such a skill set, when this may not be the case."

This study references some great sources for enhancing question writing skills. It gives examples of good and bad questions. I also highly recommend the NBME workshops on question writing. They have a terrific workbook – that can be obtained for a nominal fee.

Do you use home grown (self written) examinations?
Do you have formal training in writing questions? (Steve Miller, MD)

3. Howell LP, Hogarth M, Anders TF
Creating a Mission-based Reporting System at an Academic Health Center.
Acad Med 2002;77: 130-138.

Reviewer: Bob Swantz, MD

This paper is a descriptive account of the University of California Davis experience from 1998-2001 to develop and implement a mission-based reporting (MBR) system for university health system faculty. The goal of this project was to create a measurement tool for self-reporting of faculty activities in four key areas: research and creative work, clinical service, education, and administration/ university /community service. The MBR system was designed to assess activities quantitatively (time) as well as qualitatively (effort), with the primary objective to provide information for use by department chairs to counsel faculty regarding performance.

The system is a secure, web-based application for faculty self-reporting, that addresses each of the four missions, with sections for recording activities (quantitative) and evaluation (qualitative). Representative faculty committees were established to define parameters for each of the missions, including an estimate of time to complete each activity (50-hour workweek was the norm!) and a list of standards reflecting the quality of work performed. Using the inputted data the MBR program computes an

estimate of time spent based on embedded RVUs and generates an automated summary "report card". The report card includes a synopsis of activity that compares targeted (per departmental manager) with actual effort, a summary of evaluation, and a quantity/quality product for each mission. The quantity/quality factors are added to obtain a single summary score that correlates to established ranges of performance (expected and appropriate, substandard, or outstanding). The summary can be reviewed and validated by the individual and the department chair.

The article further details the three phases of implementation of the MBR system, during which a variety of modifications to the RVUs occurred, including stratification of RVU coding by faculty rank, differential weighting based on track, refinement of allocation of teaching/clinical missions when working with residents, and unblinding the RVUs. The authors concluded that the MBR system depicted activities of most faculty accurately, with the ability to separate quantitative and qualitative measurements. Limitations of the system included the considerable resistance of faculty, due to concerns over reliability, validity, and the time required for completing the survey. Department chairs were enthusiastic about the system and the authors concluded that the tool could be useful but needed streamlining.

This descriptive report is well written and addresses one of the contemporary issues in medical education, tracking faculty time and effort. The UCD system is of particular interest to educators because it defines "investigative and creative work" to include scholarship of education, application, and integration, as well as scholarship of discovery (traditional research). Some readers may find the article too narrowly focused because the authors de-emphasize the management aspect of the system (defining expenditures and allocating resources), however the report details a very systematic, thoughtful approach to develop a reporting method applicable across a university health system in both clinical and basic science departments. Although one of the clear strengths of the system is the testing/validation process to refine the RVUs, the authors acknowledge that faculty trust and buy-in are essential for the success of any MBR system.

It is also of interest that most faculty received a score of > 100% - showing how much work most people were doing. However, the skepticism remains – given the limited validity of this method – can it be misused This reminds me of the discussion students have about grading in third year clerkships - is it better to base most of the grade on global ratings by faculty or on a combination of quantitative methods of assessments – such as written exams.

Do you base at least 90% of clerkship grades on global scores by residents and faculty and no more than 10% on written assignments, OSCE's, SP"s, written exams and other "objective methods?

Do you – in general – favor mission based management and reporting – as opposed to the traditional – more nebulous format – of goals and expectations of faculty? (Steve Miller, MD)

4. Battistone, MJ
The Feasibility and Acceptability of Implementing Formal Evaluation Sessions and Using Descriptive Vocabulary to Assess Student Performance on a Clinical Clerkship.
Teach Learn Med 2002; 14:5-10.

Reviewer:
Sherilyn Smith, MD

Methods:
The authors implemented and studied the feasibility of using the RIME" tool for assessment of student performance on the inpatient portion of a general medicine clerkship. "RIME" describes tool in which student performance is linked with a specific set of criteria that fall into different developmental domains:Reporter-Interpreter-Manager-Educator. Students (and residents) are expected to move through each of these categories as their experience/ training progresses.

Results:
In general, residents and faculty felt that the RIME method was more valid/much more valid than other systems they had experienced. Students' responses were somewhat less enthusiastic about the RIME tool itself (2.6 +/- 1.04 on a 4 point scale, with 2=somewhat helpful and 3=generally helpful). The time spent on student feedback/evaluation was 60 minutes for the data-gathering meeting between clerkship director, faculty and residents in which the RIME tool was used and 3 hours for individual student feedback sessions (4 hours/3 week block). There was also a dedicated administrative assistant to coordinate the meetings and track down the paperwork.

Comments:
The RIME method of feedback is descriptive and has specific milestones built into its vocabulary, making it easy to understand conceptually. One of its major benefits is outlining the general behaviors of the next level, instead of performing "better than average". The major difficulty with the RIME scheme is translating an effective "feedback" tool into an evaluation scale. The specific criteria for H/P/F may be arbitrary and the authors of this study did not discuss how they translated the "feedback" into "evaluation". Unanswered questions remain whether this could be used in an outpatient setting, how would this "formative" feedback influence the summative feedback and does use of this tool change faculty/resident/students' behaviors regarding frequency and content of feedback?

This is an example of how workshops can disseminate good ideas – long before the paper is published. Actually – I heard Lewis First describe these concepts over five years ago – and I have been using them ever since – to make the language of the objectives, feedback and evaluation more explicit. Now I can tell a student he or she is functioning at a "reporter" level – and that I expect some "interpreter" behaviors – by the end of the clerkship. I have found this concept incredibly helpful in all three of these areas – objectives, feedback and evaluation – the more explicit and descriptive the language – the better each is. So two questions:
Do you think your approach to teaching has been informed more by workshops than by published articles?
Do you use the RIME method to enhance feedback, evaluation or objectives?

5. Communication between consultants and referring physicians: a qualitative study to define learning and assessment objectives in a specialty residency program ***Teaching and Learning in Medicine 14(1): 15-29.***

Reviewer: Leslie Fall, MD

Abstract: Outpatient consultation constitutes a major part of medical practice. However, little is known about the skills that should be taught to residents in order for them to improve their consultant-referring physician relationships. This qualitative study in a urologic residency program in France sought to specify the consultant skills that are required to ensure an effective communication between specialists and referring

physicians. Through a review of the literature from 1966-2000 and 6 focus groups (which included urologists, residents, referring medical specialists and general practitioners), the authors identified 2 skills sets necessary for performing excellent specialty consults. The results were broken down into 2 skill sets, the first termed "observable skills," such as identification of reason for consult and reports that are easy to read and concise. The other skill set (not surprisingly) was "principles and attitudes" such as mutual respect and cooperation, and education (of referring MD by consultant) without condescension. The discussion focuses on the need to establish both a curriculum and an evaluation strategy for testing this skill set, as well as this particular residency's experience in doing so.

Review: The current focus on teamwork skills in medicine makes this a timely paper. The paper is brief and well done. Although the paper focuses on resident education, it is clear that physician education in consultative skills, especially those of "principles and attitudes" should begin at the medical student level (yes, Steve, the hidden curriculum is alive and well!). In addition, many medical schools now have students rotate through consultation services in psychiatry, neurology and medicine in the third year. The "observable skills" described in this paper are elegantly simple and could easily be incorporated into the core curriculum for these rotations, as well as the subspecialty electives taken in the fourth year. As pediatricians on the receiving end of many consults in the inpatient and outpatient setting, we should also take the time to teach students (and residents) about the generalists' role in asking for and receiving consults, pointing out what makes an effective consult so. The skills, as described by the authors, could easily be incorporated into a great OSCE as well. These are very generalizable and important skills that can and should easily be incorporated into our teaching and evaluation.

As Leslie points out, explicitly describing the behaviors (measurable) of complex clinical skills is one of the mandates for us as clerkship directors – so as in the Battistone study above – this can really enhance our teaching.

Do you allow your students to take responsibility for making the calls to the consultants? (Steve Miller, MD)

6. Van Dalen J, Kerkhofs E, et al.
Longitudinal and Concentrated Communication Skills Programmes: Two Dutch Medical Schools Compared.
***Advances in Health Sciences Education* 2002; 7:29-40.**

Reviewer:
Linda Tewksbury, MD

As the author points out, much attention has been given to the importance of medical student communication skills training over the last 20 years. This study attempts to compare the effectiveness of two different approaches to communication skills training, a longitudinal one which is integrated over the early "pre-clinical" years of training vs. a concentrated approach which is a more condensed and introduced closer to the clinical phase of training.

The setting is two Dutch medical schools, Maastricht and Leiden, both of which have a six-year undergraduate medical curriculum divided into four pre-clinical years and two years of clinical clerkships. Mastricht has an integrated clinical skills training program (including communication skills training) which runs throughout the first four preclinical years . Leiden has a three stage

communication skills program with concentrated courses in the preclinical and clinical years including a five-week full time skills training program in 4th year.

The outcome measure used was students' performance on a 4 station OSCE involving interviews with standardized patients which required the following communication skills: clarification of a patient's exact reason for visiting the doctor, history taking and explanation, negotiation, and breaking bad news. Trained observers rated the students communication skills using MAAS-Global, a previously validated checklist, as well as an overall rating on a 10 point scale.

Fourth year and 6th year students were evaluated from each school (in Leiden, 4th year evaluations included students "pre" and "post" their intensive 5-week skills training program). Of note, Maastricht 4th year students had prior experience with multiple station OSCE's whereas the "pre" 4th year Leiden students had not. Maastricht students were also familiar with the MAAS-Global checklist whereas the Leiden students were not.

A total of 161 students participated. Maastricht 4th and 6th year students obtained significantly higher checklist scores for their communication skills than their Leiden colleagues. The Leiden scores increased from 4th to 6th year while their was no difference between the 4th and 6th year Mastricht students. On the global rating scale, 4th year Maastrich students scored significantly higher than all 4th year Leiden students but there was no difference in the 6th year students.

The author states that these results indicate the greater overall effectiveness of a longitudinal, integrated approach compared with concentrated courses. However, the author also points out that continued training in the clinical years may further enhance communication skills.

As many medical schools are undergoing major and minor curriculum restructuring, studies that attempt to measure the effectiveness of different curricular strategies can have great value. This indeed was the impetus of Van Dalen's study. However, one has to be careful in comparing the competence of students from two different medical schools as there can be many confounding variables besides differences in curriculum structuring (i.e. the Maastricht students prior experience with OSCEs and the checklist), a limitation acknowledged by the author which is addressed but still leaves questions open.

Another limitation is selection bias, as some students participated on a voluntary basis, which the author also attempts to address (comparison to non-participating students suggested there was no difference).

One way to get around such limitations would be to track the same students over time and attempt to measure a change in competency before and after the intervention (while the Leiden students were reported as improving over time, these were actually different students who may have had different baseline skills).

With more and more medical schools moving towards a longitudinal, integrative approach, it will be useful to show the benefits of such. Regarding communication skills development, Van Dalen suggests that a longitudinal, integrative approach is superior to a concentrated approach but more evidence is needed. Of additional interest, it also appears to be worthwhile to continue formalized training into the clinical years, a time when

communication skills have been shown to otherwise deteriorate.

There are a number of models of effective communication used in North America and Europe. Our last Journal Review cited the Kalamazoo Consensus Statement – which is a compilation of a number of validated and respected models. Generally, it appears that as Linda says – there is little reinforcement of these (communication) skills – formally – in the major clinical year.

Do you explicitly have a seminar in your clerkship that explicitly focuses on teaching a template for effective patient/parent communication? If yes – which one do you use? How would you describe your clerkship's approach to teaching effective communication?
(Steve Miller, MD)

7. Diana H.J.M.Dolmans et al.
The Impacts of Supervision, Patient Mix, and Numbers of Students on the Effectiveness of Clinical Rotations.
Academic Medicine 77:332-335, 2002

Reviewer:
Maxine Clarke,MD

This interesting paper reports the findings of a study to determine the most significant factor in the effectiveness of clinical rotations – supervision, patient mix or student numbers.

The study was conducted at the University of Maastricht, The Netherlands, where students spend 50% of their clinical rotations in the academic center and 50% in an affiliated regional hospital. Rotations varied from 3 – 12 weeks and all disciplines except psychiatry were included. Both inpatient and ambulatory rotations were evaluated.

Students were requested to complete a questionnaire designed to determine their perceptions of:

- the overall effectiveness of the rotation
- the supervision they received
- patient number and variety
- number of students involved in the rotation

The validity and reliability of the questionnaire was previously established.

Data from all disciplines was pooled for analysis.

Response rate varied from 71% to 90% per discipline and the results indicated that a clinical rotation's effectiveness, as perceived by the students, was most influenced by supervision and patient mix. A higher level of supervision and a higher level of patient mix resulted in a higher effectiveness score. However, there was a significant two-way interaction between supervision and patient mix - supervision had a greater impact on effectiveness when patient mix was limited. The number of students on the rotation did not significantly influence the effectiveness.

As the Director of a smaller Paediatric program, the issue of providing a valuable learning experience for students in the setting of limited patient mix is an ongoing concern. This study supports the fact that good supervision is the key to successful rotations, and emphasizes the importance of faculty development initiatives to support our teachers in providing the most effective clinical rotations.

The authors imply that supervision includes ongoing feedback – so it is the quality – of supervision – that is key – as well as the quantity. I wonder how they can be so sure that effective feedback is included in this mix?

Do you have students spend all or most of their inpatient time on a dedicated specialty service, such as Oncology or Cardiology? If so, which one? How many patients do you have student's follow on an inpatient rotation?

Do your preceptor/supervisors all provide regular feedback? What do you do to try to make this happen? (Steve Miller, MD)

8. M Tousignant and JE Des Marchais. Accuracy of student self-assessment ability compared to their own performance in a problem-based learning medical program: a correlation study.
***Advances in Health Sciences Education*; 7: 19-27, 2002.**

Reviewer: Shale Wong, MD

The authors of this study set out to look at self-assessment in a different fashion than has been previously discussed in the literature. They wanted to evaluate the ability of students trained in a PBL setting to self-assess pre and post an oral exam compared to actual individual performance on their oral exam. This technique asks an important question by looking at internal comparison measures (self-assessment vs. self performance) whereas other studies have focused primarily on self-assessment compared to external measures (i.e.) peers' or tutors' evaluation in the PBL setting. Given the importance of developing self-directed learning techniques, this study sought to offer insight to the quality and accuracy of self-assessment as a measurement tool.

While the question at face value is an important one, the methods used to test the question may not have evaluated the right issue. Two questions were asked of the student, one prior to taking an oral exam: "Do you think you can solve the problem presented?" and one post-exam: "How sure are you of your answer?" This choice of questions does not specify with any precision self-assessment of the specific items that were used on the exam checklist. Thus, instead of comparing self-assessment to performance, they compared self-confidence in ability to actual ability. Results showed only that students who consistently earned higher grades were more confident that they would do well, and did do well (higher correlation). Also, students who received feedback on their performance post exam had a higher correlation with their self-assessment post-exam. On the whole students were not otherwise able to self-assess accurately.

Another unique element to this study was using self-assessment in an exam setting. The context of an exam may significantly alter a student's sense of confidence. Since these questions evaluated confidence more than skills or performance, it's difficult to know if students are truly unable to self assess in other settings.

I like the question, "how well do students self-assess?" I also like the idea of internally comparing the self-assessment to true performance. Maybe a subsequent study should ask students checklist items similar to those used by the evaluator to truly match apples with apples and see what students really know about themselves. It also begs to answer, do we need to self assess in an exam setting or does self-assessment lend itself to pursuit of further learning without the attachment of performance. I'd like to have known whether students tended to over-estimate or underestimate their abilities. This was not clearly addressed by the authors.

Do you use self- assessment – in any form – in your school? ***How about peer - assessment?***

It strikes me that these may be useful for examining professionalism (see review by Louise Arnold - further on in this issue.)

9. Jingming Hao, MD, MS, John Estrada, MD, and Susanne Tropez-Sims, MD, MPH
The Clinical Skills Laboratory: A Cost-effective Venue for Teaching Clinical Skills to Third Year Medical Students
Academic Medicine 2002; 77:152.

Reviewer: Jamie Hoffman – Rosenfeld, MD

In this article the authors describe a clinical skills laboratory using manikins to teach clinical skills as part of the third year pediatric clerkship curriculum. They sight decreased use of hospitalization and subsequent shift toward the use of the outpatient environment for teaching as a limiting factor in student's exposure to a myriad of pediatric pathology and conditions. In addition, case mix variability may hinder the ability to find suitable patients for bedside teaching. Students may have very limited opportunities to practice invasive procedures and those which cause patient discomfort (e.g. pelvic examination).

Since the fall of 1998, the authors have used manikins in a clinical skills laboratory to teach examination and procedural skills such as lumbar puncture and the examination for a dislocated hip in an infant. Faculty members demonstrate the skills during weekly hour-long sessions and the students are encouraged to practice on their own. Later assessment of these skills is part of the summative clerkship evaluation.

The authors report that the laboratory improved student proficiency in performing the covered skills and that both students and faculty responded positively to the teaching modality in the course evaluation.

The authors conclude that selected skills can be taught as effectively in a simulated environment as in a true patient encounter with the advantage of not "taxing" patient care.

This brief report illustrates yet another innovative model to add to our teaching toolkit. As our armamentarium of simulations and multi-media teaching material grows, the challenge will be to continue to emphasize the importance of the bedside encounter and the lessons that are learned by actually touching real patients. We are already hearing from supervising faculty and house-staff that students are burying their heads in the texts or glued to on-line resources and missing important opportunities to learn from real clinical encounters.

The cost for this is worth noting – approximately $5000 start up and $2540 per year.
Do you have access to a patient simulator at our school?
Do you think students should exhibit competence in LP's by the time they complete their major clinical year?

10. Colliver J.A.
Constructivism: The view of knowledge that ended philosophy or a theory of learning and instruction?
Teaching and Learning in Medicine, 14(1), 49-51.
and Cobb P.
Theories of knowledge and instructional design: A response to Colliver.
Teaching and Learning in Medicine, 14(1), 52-55.

Reviewer: Lindsay Lane, MD

These two articles discuss the relationship of constructivism and medical education. For those of you who did not take Philosophy 101 constructivism is a philosophical theory about knowledge that views knowledge as a human social invention or "a construction". This is in contrast to the theory of realism that views knowledge as reality. These philosophical theories are

studied in the area of philosophy known as epistemology that is concerned with bridging the gap between knowledge and reality.

In his article Colliver's position is that constructivism is not a theory of learning and instruction. He makes the following key points:

1. Constructivism should be taught in order that students become aware that the knowledge they are studying in different domains is a human social construction.
2. That focusing on constructivism as a theory to use in education may blur the essential distinction between epistemology (the gap between knowledge and reality) and learning.
3. That the principles of LEARNING are the same whether we look on knowledge as a construction or a representation of reality.
4. That, despite statements #2 and #3 constructivism has important implications for curriculum development and design.

Colliver points out that modern science was based on the realist view but that this view was hard to sustain and began to give way to constructivism as scientific knowledge became increasingly abstract. Constructivism gives a more pragmatic alternative that acknowledges that even logic and reason are influenced by social and political factors. He points out that the process of learning medicine using PBL is claimed to be grounded in constructivist theory because students "actively construct learning in small groups guided by a tutor" but that this does not mean that constructivism is a theory of learning and instruction.

Although Cobb is supposedly writing a rebuttal to Colliver's article he essentially agrees with Colliver's position that a theory of knowledge cannot "become" a theory of learning and instruction but that it is important for learners to understand the theories of knowledge! What was of interest in Cobb's article was his description and discussion of teaching (he's a mathematician) using what he calls "pragmatic constructivism" to guide learning and instruction. Essentially he describes a competency -based approach to teaching by "specifying instructional goals in terms of human activities of knowing rather than in terms of static knowledge structures." He describes how this creates a learning environment that, "Is concerned with processes of enquiry as people and intellectual communities actually enact them" and "Views the teacher and students as constituting a community that establishes its own norms and practices."

Comment:
Cobb's" pragmatic constructivism " is in sync with the new emphasis on competencies and the writings of many medical educators who are concerned with "learning". It also has echoes of Knowles' description of the features of the pedagogical versus the androgogical approach to teaching. Changing the medical school curriculum so students do not learn a "realist" view i.e. that knowledge equals science and that medical practice equals bioscience, is clearly of great importance. How we go about this intellectual widening of the medical curriculum continues to be a challenge. Very often medical school courses that attempt to allow students to make sense of or "make a construct of" the subjective dimensions of medical practice, which include the patient's social matrix and the cultural, economic and political environment, are looked on as "soft". Such courses are often not taken seriously by students and are viewed in the same way by some members of the faculty.

It seems to me that Colliver and Cobb are correct: that we should be teaching our medical students basic epistemology!

Having a basic understanding of the philosophical theories about knowledge and reality would allow them to understand that the knowledge they construct about the patient's reality is just as valid as scientific knowledge about a patient's illness. More importantly, as we all know so well, this knowledge is the key to professionalism, humanism and socially responsive doctoring. (Lindsay Lane, MD)

Do you think that understanding educational theory is important for success as a medical educator? Weigh in – I think it is helpful to think about constructing learning that reinforces learners' ability to problem solve and construct their own reality – Do you all agree?
If a tree falls in the woods and no one is around – does it make a sound? (SM)

11.Inspiring Teaching
edited by John K. Roth and published by Anker Publishing Company (1997), Bolton, MA

Reviewer:
Larrie Greenberg, MD

This book is a compilation of reflective essays written by Carnegie Foundation Professors of the year. The book really represents a continuum of what Ernest Boyer, former President of the Foundation, started in his report entitled- *Scholarship Reconsidered: Priorities of the Professiorate* (1990) in which he addresses the different forms of scholarship in higher education. The book focuses on excellence in and the scholarship of teaching as evident from the title. Whereas only one chapter is written by a health care professional, a nurse, I believe COMSEP members will relate to many of the essays. Such as 'Relations of mutual trust and objects of common interest, What makes a good teacher, Classroom atmosphere: A personal inventory, and Competence, creativity, collaboration and caring', among others. Roth, as editor, then summarizes what the book meant to him.

The title may be misleading as a major focus is not the teacher, but the learner; and how the teacher must establish trust and empower the learner, two issues our faculty have not succeeded in doing well. All in all, this book is a wonderful concentration of personal classroom stories by outstanding and amazingly creative teachers. The principles are very well applicable to what we do clinically. The book is worth a look.

Heimlich, JE & Norland, E Developing Teaching Style in Adult Education Jossey-Bass, San Francisco, 1994

Larrie Greenberg, MD

This book is a wonderful guide that is directed towards teachers who interact with learners in many settings. Unlike other educational books, it does not dwell on theory but focuses on everyday practice. Whereas it is not specifically aimed at the medical profession, you will see many applications towards our teaching responsibilities in the clinical arena. The authors have divided the book into three parts:

1) Explaining the personal side of teaching;
2) Reflecting on the teaching and learning exchange; and
3) Integrating teaching concepts with teaching style.

These are introduced in a logical order with part one exploring historical and current perspectives on and definition of teaching style in addition to the teaching-learning relationship. Part two

focuses on the variables that comprise the educational interaction; namely, environment, curriculum, teacher, learner, and learning community. Part three addresses application of teaching styles. Whereas the book is written by educators in higher education for colleagues of the same ilk, it is easily readable for those of you who have mastered some of the educational jargon. A new concept for me was the 'learning community' in which we teach, incorporating issues like culture, types of learning communities, and how the educator relates to learners.

I liked the book and am reading specific parts for a second time in preparation for a master teachers' course at Children's National Medical Center in which I am co-facilitating the parts on learning. A major strength is that it addresses teaching more than learning, one of the few books I have found to do such. However, make no mistake... you can't have one without the other!!!!!

Other notable publications:

1. M Regan-Smith et al,
An Efficient and Effective teaching Model for Ambulatory Education,
***Acad Med* 77: 593-599 2002**

This article describes three examples of outpatient education that work. Example #2 includes presenting in front of the parents. All the models rely on using two rooms. Take home points for any model are: 1) Student must play an active role, 2) Pre learning must be done (an explicit orientation – including – and this is great – scripts on how to carry out certain tasks – some written out - verbatim and 3) Time for feedback and teaching.

Do you have students present patients in front of the patient and family?
Do you use teaching scripts? (not handouts – but written dialogues). (SM)

2. Misch D,
Evaluating Professionalism
***Acad Med* 77, 489 and**

3. Arnold L,
Assessing professional behavior,
Acad Med, 502

These two papers shed important light on the challenge of evaluating humanism and professionalism. Both authors focus on the need for qualitative assessment – which includes – developing an explicit language to describe humanistic doctoring. Misch goes so far to say that the average doctor cannot do this, he advocates for the development of connoisseurs – or critics – much like a film or art critic – who would need to have the time to do extensive real time observation – in order to write their review. Imagine – being reviewed in the ***NY Times*** for you humanism. Arnold provides an exhaustive look at the pluses and minuses of current tools – in her usual scholarly way. Bottom line – need to develop portfolios – including quantitative and qualitative tools – and the current tools – especially quantitative – need work.

How would you quantify the ability to: "sense the individual uniqueness of a patient and adjust management/treatment accordingly."? (SM)

4. Wear D,
The House of God
***Acad Med, 77, 496* and**

5. Ginsburg S, et al.
The Anatomy of the Professional Lapse,
Acad Med 77, 516

These are two terrific papers on the essence of humanism and professionalism. Wear tells us that House of God is still relevant today and Ginsburg highlights the specific contexts that bring humanism and professionalism to a head – that is – the conflicts of every day medicine through the eyes of a student. Both papers shed light

on the details of humanistic behavior – that are needed to assess it when you see it. To be self serving - Ginsburg's paper validates the importance of context and conflict –that are the center piece of a behavioral model of humanism that we've worked on at Columbia – the so called habits of the humanistic physician (Miller and Schmidt *Acad Med 1999)* Other pertinent papers on professionalism and humanism can be found in the June issue of Medical Education and Academic Medicine.

Do you think medicine is drastically better than what was portrayed in the House of God – both then? And now? (SM)

6. Fields S, et al (including Fred McCurdy)
Clerkship Directors and HCFA Regulations
Acad Med, 77, 543

This study reviews the perceived problems that HCFA regs place on student education. (SM)

7. Berner E et al (including Bill Raszka, Andy Spooner and Roger Berkow)
A Model for Assessing Information Retrieval Skills
Acad Med 77, 547

This is a study which demonstrates the effectiveness of teaching information retrieval – an evidence based medicine and life long learning competency – using an informatics curriculum and demonstrated the validity of using OSCE's to assess the skill. Strong work by a number of COMSEP members.

Do you have an explicit evidence based medicine or informatics curriculum for your clerkship? If yes, which one? (SM)

8. Shea J and Bellini L, Evaluations of Clinical Faculty, *Teaching and Learning*, 14(2) 87

This is a fascinating paper – which suggests that students become less critical of faculty as the year goes on and residents become more critical. The authors caution the interpretation of faculty evaluations for promotions – without taking this into account.

And finally, to keep this issue on the intellectual level established by the superb literature review, I present the following:

1. Don't sweat the petty things and don't pet the sweaty things.

2. One tequila, two tequila, three tequila, floor.

3. Atheism is a non-prophet organization.

4. If man evolved from monkeys and apes, why do we still have monkeys and apes?

5. I went to a bookstore and asked the saleswoman "Where's the self-help section?" She said if she told me, it would defeat the purpose.

6. What if there were no hypothetical questions?

7. If a deaf person swears, does his mother wash his hands with soap?

8. If a man is standing in the middle of the forest speaking and there is no woman around to hear him ... is he still wrong?

9. If someone with multiple personalities threatens to kill himself, is it considered a hostage situation?

10. Is there another word for synonym?

11. Isn't it a bit unnerving that doctors call what they do "practice"?

12. Where do forest rangers go to "get away from it all?"

13. What do you do when you see an endangered animal eating an endangered plant?

14. If a parsley farmer is sued, can they garnish his wages?

15. Would a fly without wings be called a walk?

16. Why do they lock gas station bathrooms? Are they afraid someone will clean them?

17. If a turtle doesn't have a shell, is he homeless or naked?

18. Why don't sheep shrink when it rains?

19. Can vegetarians eat animal crackers?

20. If the police arrest a mime, do they tell him he has the right to remain silent?

21. Why do they put Braille on the drive-through bank machines?

22. How do they get the deer to cross at that yellow road sign?

23. Is it true that cannibals don't eat clowns because they taste funny?

24. What was the best thing before sliced bread?

25. One nice thing about egotists: they don't talk about other people.

26. Does the Little Mermaid wear an algebra?

27. Do infants enjoy infancy as much as adults enjoy adultery?

28. How is it possible to have a civil war?

29. If one synchronized swimmer drowns, do the rest drown, too?

30. If you ate pasta and antipasto, would you still be hungry?

31. If you try to fail, and succeed, which have you done?

32. Whose cruel idea was it for the word "Lisp" to have a "S" in it?

33. Why are hemorrhoids called "hemorrhoids" instead of "assteroids"?

34. Why is it called tourist season if we can't shoot at them?

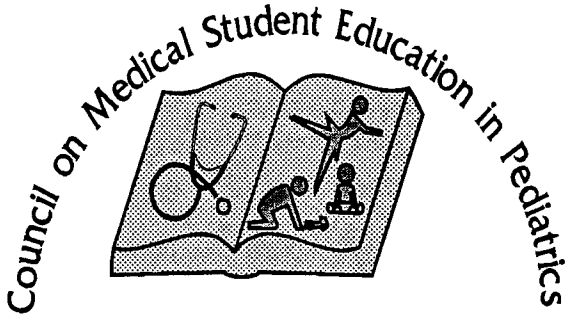
35. Why is the alphabet in that order? Is it because of that song?

36. If the "black box" flight recorder is never damaged during a plane crash, why isn't

the whole airplane made out of that stuff?

37. Why is there an expiration date on sour cream?

The Pediatric Educator



Volume 9 Issue 1 **Winter 2002**

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

Comments from our President, Richard Sarkin

President's Column

Winter greetings from Western New York! I hope all goes well. I am eagerly looking forward to the 2002 COMSEP meeting at the Nashville Hilton Suites from 3/14-17/02. We have an exciting, action-packed meeting planned, as COMSEP celebrates its 10th anniversary. We have invited O.J. Sahler from Rochester, COMSEP's founder and 1st President, to attend the Nashville meeting and provide a bit of historical perspective when she addresses our group.

The theme for one morning of the 2002 meeting will be "Teaching Cultural Diversity and Culturally Sensitive Care" with former Surgeon General, Jocelyn Elders, delivering a keynote address. During the meeting, we will offer over 20 different workshops on a wide range of topics related to medical student education in Pediatrics. We have several different social events planned including a Saturday night dinner at the Frist Center for the Visual Arts featuring the Fisk University Jubilee Singers. I want to thank Billy Bob Janco from Vanderbilt for all his hard work in hosting the 2002 meeting. As you can tell from Bob's remarks in this issue of the Pediatric Educator, there's plenty of fun stuff to do in Nashville.

Once we leave Nashville in March, our thoughts will turn to Rocky Mountain Robin (Deterding) from Colorado who will be hosting the 2003 COMSEP meeting outside of Denver at the lovely Omni/Interlocken Resort from 4/3/03-4/6/03. For those of you whose PDA's reach that far in advance, the 2004 COMSEP meeting will be held jointly with AMSPDC from 3/3-8/04 at the Marriott Bay Point Village Resort in Panama City, Florida.

I want to make sure you are aware that the COMSEP Web Site is in the process of being completely revised and overhauled by a commercial web site design company

and then reviewed all articles in Academic Medicine and Medical Education for 2 two-year periods for evidence of any form of documentation. Overall they found that 27% of articles mentioned the source of funding, 23% mentioned informed consent, 22% mentioned participant confidentiality and only 5% mentioned IRB review. Almost half (47%) mentioned none of the safeguards. Qualitative review revealed significant variability in documentation of these features. The study's inter-rater reliability was very good (0.7-1.0). The authors conclude by stating that their intention is to raise awareness of what they believe is the neglected issues of safeguards in education research and practice. They suggest that medical education faces a serious problem in living up to the emerging standards of ethics and accountability in human research. They call for further dialogue and set standards for the ethical aspects of research and scholarly practice in medical education.

The only real limitation of the study was that the authors were only able to determine whether or not these key features were included in the written paper, not if the features were included in the actual study. Although a few of the authors' conclusions are somewhat overstated, I find this article a refreshing "call to arms." As the level of rigor in medical education research rises, so too should the level of professionalism and ethics. Given that this article was included in an issue of Academic Medicine largely devoted to issues surrounding publishing in medical education, this article is a must read for anyone currently conducting and intending to publish medical education research. I know it made me re-think some aspects of the CLIPP evaluation plan. Leslie Fall, MD

How many of you believe that all education research needs IRB approval? Would you use data from previous classes as "baseline data" – or report class board scores as part of a descriptive paper without IRB approval? What about a paper that describes a program or a change in your curriculum? Do routine learner assessments and program evaluation need prior IRB approval for use in a study? How do any of you handle this? (Steve Miller, MD)

2. Henry R, Wright D, When do medical students become human subjects research?
Academic Medicine 2001; 76:876-885
Reviewer: Steve Miller, MD

This paper addresses the same issue as the first study. The author's (from Michigan State) argue that although the federal regulations exempt:

research conducted in established educational settings, involving normal educational practices, such as I) research on regular and special educational strategies, or ii) research on the effectiveness of or comparisons among instructional techniques or methods ...

that educators should: a) let the IRB decide, and not decide on their own to skip approval and b) use a blanket approval from students at the beginning of each year – for consent to use all evaluation data for research purposes – to model professionalism.

What do you all think? Do you agree with this approach? What have all of you experienced? Do you think that no paper should be accepted for publication – if IRB approval was not specifically signed off on by the first author? (Steve

Miller, MD)
3. **Papadakis M, Loeser H** (Longstanding COMSEP member and former APA SIG Chair), **Healy K, Early detection and evaluation of professionalism** ***Acad Med.*** **2001; 76:1100-1106**

Reviewer: Jamie Rosenfeld, MD – Albert Einstein School of Medicine (Also – my chief resident – when I was an intern - SM)

Since 1995, the UCSF Medical School faculty has employed a strategy for detecting and evaluating medical students' unprofessional behavior. An earlier report by the same authors (Academic Medicine, Vol. 74, #9, September 1999) described the system whereby faculty used a Physicianship Evaluation Form to document concerns within the domain of interpersonal skills. This form is different and separate from the standard clerkship evaluation.

The current article describes the experience of expanding the evaluation strategy into the first and second, primarily pre-clinical, years of medical school. The expressed goal was to identify medical students with problem behaviors so that early remediation can be instituted prior to the student embarking on clinical rotations.

The original Physicianship Evaluation Form was adapted to fit the professional development issues specific to the first two years emphasizing student relationships with peers, staff and faculty. A section of the form deals with upholding the Medical Student Statement of Principles, a code of conduct.

When a form is generated by a faculty preceptor, it triggers a meeting between the student and the course director who can provide the student with feedback about the preceptor's concerns. If the course director feels that the report has merit, it is sent to the Associate Dean for Student Affairs who meets with the student.

Consequences for a first or second year student of having a report filed are not as significant as those that result from a report during the third and fourth years. No mention is made of the process in the Dean's Letter for residency and the student is not necessarily placed on academic probation. In this way the process, in the first two years, is primarily feedback as opposed to evaluation. However, having had a Physicianship Evaluation Form generated in the first two years does lower the threshold for severe consequences if further reports are generated in the clinical years.

Since its implementation, the UCSF faculty rapidly embraced the use of the form and it has been incorporated into the medical school culture. Acceptance by the student body was described as "generally favorable." There have not been any measured outcomes; the number of times the strategy has been employed for a first or second year student appeared to be small.

This descriptive report generates a number of researchable questions. How accurately are we in identifying first and second year medical students who will have behavioral problems in their clinical years? Does early identification and remediation have any effect in modulating students non-cognitive skills? Does such a strategy reduce or increase faculty reluctance to giving immediate and effective feedback? Does the existence of such a form have any effect on faculty resistance to documenting and reporting students with behavior problems? (Jamie Rosenfeld, MD)

How many of your schools have similar evaluations? Does your school allow for dismissal – even if a student passes all courses? Finally,

this evaluation of professionalism targets "outlier" behavior. Do you think it affects the behavior of the average student – who has lapses in professionalism? (In other words, is unprofessional behavior generally a character flaw observed in a "bad person" – or a lapse in behavior by any one of us?) Steve Miller, MD

4. **A Clinical Performance Exercise for Medicine-Pediatrics Residents Emphasizing Complex Psychosocial Skills**
Duke MB, Griffith CH, Haist SA, Wilson JF.
***Academic Med* 2001; 1153-1157**

Reviewer: Michael A. Barone, M.D. Johns Hopkins University (APA SIG working group member – although – only in his second year – at COMSEP – a major contributor – hopefully will not go to New Zealand – like his predecessor John Andrews)

The authors note that many university based residency graduates (in this case med-peds) are under prepared to counsel patients with complex psychosocial problems (CPSP). The investigators have previously published these survey data (Teach Learn Med 1999; 11:80-4). Using a combination of standardized patient (SP) and non-SP stations, 25 med-peds residents (PL-1 and PL-3) were evaluated using a clinical performance exercise (CPE) designed by the investigators to focus on the management of clinical encounters with CPSP.

The assessment tool was labor intensive. A thirteen station, 4+ hour CPE was created and administered on a Saturday; coverage was provided for the residents. Eight of thirteen stations assessed CPSP using SP's who had been pre-tested for reliability in scoring. Examples of difficult CPSP included domestic violence, sex abuse and giving bad news. Outcomes were 1) correctly identified issues by the trainee 2) an assessment of general interview skills and 3) bedside manner as measured by the SP's.

Overall, residents performed less well on counseling for CPSP compared to common problems such as newborn discharge instructions. Third year residents performed better in the development of a "plan" to address important items on the SP exam but did no better than PL-1's in the awareness or "assessment" of these items. Residents and faculty were reported to have "valued" the exercise, although no quantitative data were presented for this.

This study is a good first step toward identifying a likely curriculum deficiency in many programs. One can imagine many ways to create an intervention to address this. I am reminded that teaching students and residents good communication skills does not necessarily mean they can effectively help patients with CPSP. Are the authors' findings generalizable? Likely yes, although one can speculate that local factors in training programs could provide more opportunity for some residents to develop their counseling skills in certain clinical settings (e.g. HIV prevalence). Mike Barone, MD

Do you think that medical student graduates should be competent in the skills of "giving bad new", "dealing with domestic violence", "dealing with sexual abuse' etc.? How many of you explicitly evaluate competence in these areas within your clerkship – in a high stakes way? How about - within your school? Should someone pass Pediatrics without demonstrating competence in these areas? Should the

ABP test us on these in our re-certification exams? Steve Miller, MD

5 and 6. Weaver L. & Hall P. Interdisciplinary education and teamwork: a long winding road. ***Medical Education,*** 2001;35:867-875.

Prystowsky J.B., DaRosa D.A., Thompson J.A. Promoting collaborative teaching in clinical education. ***Teaching and Learning in Medicine,*** **2001;13:148-152.**

Reviewer: Lindsay Lane, MD (Longstanding COMSEP member – APA SIG associate chair – originally from the UK)

I am reviewing these articles together as they highlight the need for both interdisciplinary teaching and learning and interdisciplinary medical practice.

In their article Weaver and Hill provide a comprehensive overview of the literature on interdisciplinary teamwork, they define the different types of teams (multidisciplinary, interdisciplinary and transdisciplinary) and discuss the skills practitioners need to acquire to be competent members of teams. They review the evidence about when the best time to introduce training in team skills into the medical education curriculum is and conclude that there is no consensus. In contrast they emphasize that there is consensus on the *need* for an interdisciplinary component in the healthcare professional's education.

Prystowsky et al report the results of a survey of clinical course directors at NWU medical school. The survey showed that 90% of clinical topics were listed as primary or secondary in another clinical course, and that there were 12 clinical problems that at least 5 course directors considered of primary or secondary importance. Because of this "clinical overlap" they make a good case for interdisciplinary teaching in order to; 1. Eliminate "academic provincialism" and enable the student to see the big picture, 2. Eliminate redundancy, 3. Reinforce learning and promote development of higher level understanding, and 4. Better coordinate student evaluation. Note that if you substitute the words "physician" for "student" and "patient care" for "learning" and "evaluation" in the 4 reasons to have interdisciplinary teaching they are transformed into the 4 reasons to have interdisciplinary patient care! Clearly we need to develop and use our teamwork skills to both teach and take care of patients.

It is not news to any COMSEP member that there are significant barriers to interdisciplinary teaching and that for faculty to participate in this type of teaching extensive faculty development is needed. Indeed Hall and Weaver observe that the concept of interdisciplinary teamwork did not originate in the university health sciences' centers but was formulated by practitioners on the front-line and that the physical layout and traditional approach of medical schools are not conducive to interdisciplinary concepts. One big surprise is that Hall and Weaver could not find any reports of "specific examples of collaborative clinical teaching modules for medical student education" when doing their literature search. Surely this can't be true! This is an important topic and COMSEP members should share their experience with curricula that use interdisciplinary clinical teaching not only by giving workshops and writing abstracts but also by publication in the medical education literature. Lindsay Lane, MD

How many of you participate in interdisciplinary teaching? Do you think that we should have "borderless" clerkships – eg. maternal and child health – co facilitated by Pediatrics and OB/Gyn – with intermingled clinical experiences? Or – should interdisciplinary teaching be limited to the fringes – eg. in some didactic or case based teaching? How many people believe that eliminating redundancy – in this way – is a good outcome? Finally, how many of you believe that interdisciplinary teaching should include nursing and other staff members – in a high stakes way (not just in the fringes – with a case discussion here and there)? How about having shared classes with nursing students?
Steve Miller, MD

6. **Medical error: a discussion of the medical construction of error and suggestions for reforms of medical education to decrease error. Lester H, Tritter JQ. Medical Education 2001; 35 (9): 855-861.**

Reviewer: Randy Rockney, MD Brown University (Who would have guessed – that this long standing COMSEP member – who has a special interest in medicine and literature – hails from Hawaii – and his family has a house there – so be especially nice to him).

Spurred by a "growing public perception that serious medical error is commonplace and largely tolerated by the medical profession," these two British authors present a review of the literature on medical error and its relationship to medical socialization especially as it occurs in medical student education. Medical error is defined as "an actual or potential serious lapse in the standard of care provided to a patient, or harm caused to a patient through the performance of a health service or a health care professional." The authors' review three studies of physician attitude toward medical error, two from the U.S. and one from the U.K., and identify patterns of thinking about and explaining medical error common to most physicians. These patterns of thinking include an emphasis on the uncertainty of medical work, the necessity of fallibility, the perception of the exclusivity of medical judgement, the extensive use of medical networks when faced with a medical error, and the externalization of blame towards the patient or the managerial system. All these patterns of thinking have their origins in medical education and the process of professional socialization. Most current efforts to address the problem of medical error, the authors assert, reforms based on naming, blaming and shaming individual practitioners, are largely doomed to failure because they fail to address the root causes of the perceived tolerance of medical error. "Medical educationalists" (that's us in British parlance) have the opportunity and the responsibility to reform the aspects of medical education and professional socialization that help create and perpetuate the existence of avoidable error, and reinforce medical collusion of error.

Do you all remember the ABC's of medicine – Accuse, Blame and Criticize? (At least in NYC) How does that contribute to collusion to hide our errors? Do any of you specifically teach about medical errors in your clerkship? If so, how? Is this covered in the pre – major clinical year curriculum at your school? Is "competence" in this

area evaluated? What is your personal approach and advice in this area? What is your institution's approach (department, hospital, school)? Food for thought.
Steve Miller, MD

7. **Hampshire A, Avery A, What can students learn from studying literature?** *Med Ed* **2001;35:687-690**

This paper describes a fourth year clerkship in which students were given the option of taking one day off of their clinical responsibilities to read a short piece of their choice and write about it. 8/11 took the option and self reported that they felt that this enhanced their appreciation of the patient's and family member's perspective of illness.
Rita Charon – an internist here at Columbia – has espoused "narrative medicine" as a tool for enhancing compassion and imagination in practitioners. Look for her study on the "parallel chart". After all – understanding the patient's perspective and the potential conflict with our perspective – is a central challenge to humanistic doctoring. This is a shameless plug for the description of the humanistic habit of medicine – that we worked on at Columbia. Virginia Randall – COMSEP member – has also used this construct to make humanistic care more concrete. Steve Miller, MD

How many of you incorporate the arts in your clerkship? How many of you require it/ How many – provide an elective experience (within the clerkship)? If so – how? Who believes that the arts and humanities should be an explicit requirement of medical training? List your favorite movie of all time? Your favorite "medical" movie? How about book and "medical" book? Painting? Let's see what the collective tastes of COMSEP members are – send me your answers – and I'll compile a list for the group.

9. **Vichitvejpaisal P, et al. Does computer assisted instruction really help to improve learning? Med Ed; 2001;35:983-989**

This study compares self learning of skills in blood gas interpretation through a text based format versus an interactive computer format. The text based format resulted in better immediate post test scores – but at 6 week post test scores were the same. Wow. Take home points? They said that the computer format took longer – and students couldn't finish it in the same time as the text format. They felt that text format could be more efficient.

So, do you believe that computer based teaching is inherently better than text based teaching (just your gut feeling)? Does computer based teaching need to be even better than text based – because it may be more labor intensive? How would you argue for computer based testing based on these results? When could computer based testing be a better tool?
(Robin Deterding and Leslie Fall – could you guys chime in here?) Steve Miller, MD

10. **Engleberg NC, et al. Learning styles and perceptions of the value of various learning modalities, Teaching and Learning in Medicine, 13(4), 253-257**

The interesting part of this study is that – even though students with certain learning styles said they preferred certain learning formats – they assessed learning experiences after the fact equally. How do we explain this? Well, its obvious that quality and content –

supercede type of approach. In other words – a great lecture is better than a mediocre problem based session. So, changing the format – doesn't always improve quality.

How many of you prefer to teach by giving a formal lecture? What is more difficult for you – giving a formal lecture – or running a small group discussion? How many of you have more formal lectures in your clerkship than small group discussions? Steve Miller, MD

11. **Lin C-T, et al. Personalized remedial intensive training of one medical student in communication and interview skills. Teaching and Learning in Medicine, 13(4), 232-239**

Many people feel that certain skills – especially interpersonal skills – are impossible to remediate. Here is a great description of terrific – although labor intensive work – to remediate a student's communication skills. It also highlights the Bayer Communication model – which is one excellent model for teaching effective communication. Rich Sarkin is a member of the Bayer faculty.

How does your school remediate students with interpersonal skill deficiencies? What about professionalism deficiencies? How about reasoning difficulties – and learning challenges? What role do you play as clerkship director? Steve Miller, MD

12. **Wright S, Carrese J, Which values do attending physicians try to pass on to house officers? Medical Education 2001,35;941-945**

The authors asked faculty to identify a single attitude or value that they try to pass on to house officers. The authors felt that the data show that attendings do try to pass on values and attitudes. However, only 78% of attendings could articulate a value explicitly, and the 78% that did – used vague phrases that are difficult to operationalize. This is one of the major problems with teaching values – if you can't even label them to your learners – it will be difficult to "teach" or promote them. ***Do you think that you need to explicitly identify a value in order to teach it? How would you answer the question: What single value or attitude do you try to pass on to your learners?***

13. **de Saintonge DM, Dunn DM, Gender and achievement in clinical medical education, Medical Education 2001,35;1024-1033**

The authors looked at the self attribution styles of students and linked them to academic achievement. It seems that men generally - when the situation is stressful - perform well – because they are "aroused" to succeed – often in response to fear of negative evaluation. Women – on the other hand – seem to do well – in stressful situations – by realizing that the stress was external to themselves – and that they needed to change the environment – or their expectations to succeed. They were less driven by fear of poor evaluation – and less likely to see these challenges as a measure of their own innate talent. Therefore – women are more adversely affected by unresponsive learning environments – that will not change in response to their input.

What do you see as the implications of this research? Do you think that there is a difference between how men and women tend to function in medical school? If so, what is the difference

– and what are the implications?

14. **Bordage G. Reasons reviewers reject and accept manuscripts: Acad Med. 2001;76:889-896**

Dr. Bordage provides insight into mistakes that hamper medical educators in getting their work published. He identifies problems that can be fixed(wrong statistics and overstating conclusions) and fatal flaws (ignoring current literature, poor study design and poor writing). Obviously, fatal flaws need to be addressed up front. Ironically, he also describes what can be interpreted as unreliable reviewing. Inter rater reliability for reviewers is only 0.25. Reviewers do not consistently check off the reasons for rejection – they must be gleaned from the narrative. Overall, this study and the entire issue of Academic Medicine – provides insight into a more successful approach to writing.

Have you had a paper (related to medical education) rejected this year? Have you had a paper accepted? Have you been discouraged from writing after a rejection? Are you keeping an educator's portfolio in order to keep track of other academic contributions you make? (Steve Miller, MD)

I think we'll need another issue of the Pediatric Educator just to answer all of Steve's questions!

And finally, to conclude this issue of the Pediatric Educator, I present words of wisdom "from the mouths of babes".

Love according to 4-8 year olds . . . (and we think they don't notice!!)

A group of professional people posed this question to a group of 4 to 8 year-olds, "What does love mean?" The answers they got were broader and deeper than anyone could have imagined. See what you think:

"When my grandmother got arthritis, she couldn't bend over and paint her toenails anymore. So my grandfather does it for her all the time, even when his hands got arthritis too. That's love." ...Rebecca - age 8

"When someone loves you, the way they say your name is different. You know that your name is safe in their mouth." ... Billy - age 4

"Love is when a girl puts on perfume and a boy puts on shaving cologne and they go out and smell each other." .. Karl - age 5

"Love is when you go out to eat and give somebody most of your French fries without making them give you any of theirs." ... Chrissy - age 6

"Love is what makes you smile when you're tired." ... Terry - age 4

"Love is when my mommy makes coffee for my daddy and she takes a sip before giving it to him, to make sure the taste is OK." ... Danny - age 7

"Love is when you kiss all the time. Then when you get tired of kissing, you still want to be together and you talk more. My mommy and Daddy are like that. They look gross when they kiss" ... Emily - age 8

"Love is what's in the room with you at Christmas if you stop opening presents and listen," ... Bobby - age 5

"If you want to learn to love better, you should start with a friend who you hate." ... Nikka - age 6

"Love is when you tell a guy you like his shirt, then he

wears it everyday." ... Noelle - age 7

"Love is like a little old woman and a little old man who are still friends even after they know each other so well." ... Tommy - age 6

"During my piano recital, I was on a stage and scared. I looked at all the people watching me and saw my daddy waving and smiling. He was the only one doing that. I wasn't scared anymore," ... Cindy - age 8

"My mommy loves me more than anybody. You don't see anyone else kissing me to sleep at night." ... Clare - Age 5

"Love is when mommy gives daddy the best piece of chicken"... Elaine - age 5

"Love is when mommy sees daddy smelly and sweaty and still says he is handsomer than Robert Redford." ... Chris - age 8

"I know my older sister loves me because she gives me all her old clothes and has to go out and buy new ones." .. Lauren - age 4

"I let my big sister pick on me because my Mom says she only picks on me because she loves me. So I pick on my baby sister because I love her."
...Bethany - age 4

"When you love somebody, your eyelashes go up and down and little stars come out of you." ...Karen - age 7

"You really shouldn't say 'I love you' unless you mean it. But if you mean it, you should say it a lot. People forget," ...Jessica - age 8

And finally,
Kids say the darndest things

HOW DO YOU DECIDE WHO TO MARRY?

You got to find somebody who likes the same stuff. Like, if you like sports, she should like it that you like sports, and she should keep the chips and dip coming. --Alan, age 10

WHAT IS THE RIGHT AGE TO GET MARRIED?

Twenty-three is the best age because you know the person FOREVER by then. --Camille, age 10

No age is good to get married at. You got to be a fool to get married. --Freddie, age 6

HOW CAN A STRANGER TELL IF TWO PEOPLE ARE MARRIED?

You might have to guess, based on whether they seem to be yelling at the same kids. --Derrick, age 8

WHAT DO YOU THINK YOUR MOM AND DAD HAVE IN COMMON?

Both don't want any more kids. --Lori, age 8

WHAT DO MOST PEOPLE DO ON A DATE?

On the first date, they just tell each other lies, and that usually gets them interested enough to go for a second date. --Martin, age 10

WHEN IS IT OKAY TO KISS SOMEONE?

When they're rich.--Pam, age 7

The rule goes like this: If you kiss someone, then you should marry them and have kids with them. It's the right thing to do. --Howard, age 8

"And the #1 Favorite is....."

HOW WOULD YOU MAKE A MARRIAGE WORK?

Tell your wife that she looks pretty, even if she looks like a truck. ---Ricky, age 10

See All Y'all (plural of y'all)
In Tennessee in March

Nashville
March 14-17, 2002