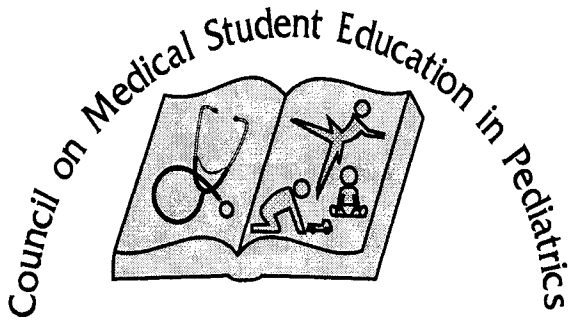
# The Pediatric Educator

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**Editor:**
Gary Freed, D.O.
Emory University School of Medicine

*Comments from our President, Bruce Morgenstern*

***President's Message***

Where did I misplace two months? It seems like just yesterday that I was climbing a mountain in a sudden thunder-snow storm, and then enjoying a great dinner at the Chatuaqua. I want, once again, to thank Robin and Shale as well as Lisa and Jean for making the meeting in Colorado so successful and so much fun for me.

We are already hard at work on COMSEP 2004, which will be a joint meeting with the Chairs in Panama City, FL. The planning committee for the meeting is made up of Rich Sarkin (he's done this before), Steve Miller, and me. We have already lined up Deb Simpson, a great medical educator and advocate for academic promotion for those of us who teach. Deb will speak at a combined AMSPDC/COMSEP plenary on the topic of educational scholarship.

As some of you know, at these combined meetings, we do some COMSEP-only workshops and we do workshops to which the chairs are invited. This latter group takes some special planning and thought, and works better if the workshop leaders include both COMSEP members and chairs. It's a good time for you to think about possible workshops that either you'd like to do with a chair (not necessarily your own) or that you do not feel you can do, but that you think chairs and clerkship directors would enjoy. Please contact Rich, Steve or me if you have ideas or want to volunteer.

So, what's new with COMSEP? Lots of small things and one big thing, I think. The small things include our participation, through our association with the Alliance for Clinical Education, in an AAMC-sponsored task force on Clinical Skills Education of Medical Students. Ben Siegel, Sandy Sanguino and I are working to see where this process is headed, and how COMSEP can remain actively involved. You'll hear more as we know more. The group has only met once so far.

COMSEP is also working with the APPD on letters of recommendation, and an AMSPDC-pages commentary will be coming in August. There are data from a survey that you have heard presented by Stu Slavin. We continue to look for

other ways to collaborate with our APPD colleagues. I was happy to hear discussion at the APPD meeting in May that APPD and COMSEP should meet together, since we share so many issues,

The Research Task Force, after organizing a great oral and poster session in Colorado, has submitted some of the abstracts to the journal, *Teaching and Learning in Medicine* (TLM), and we will see many of them in print soon. Speaking of print, the article to which I referred in my talk at COMSEP, Expectations of and for Clerkship Directors, will be coming out in the next issue. Let me know if you need/want a copy. The authors are quite hopeful that the paper will be a help to clerkship directors everywhere. The TLM editors have also seen what Steve Miller and his group have done with the journal review and want to see if COMSEP can do something like that for their journal. You'll likely be hearing more about this soon.

Finally, you will see elsewhere in the Educator a copy of a work in progress, the document that the COMSEP Executive Committee spent six hours developing at a planning meeting in Colorado the day before the COMSEP meeting began. The people who worked on that effort have my deepest gratitude. They stuck in there and made some real progress in helping us get our core work better focused. What you will read is still being developed, but we think it's ready for some broader input.

I hope to see many of you at the AAMC. If not, at least send me some e-mails. Keep up the good work!

***Strategic Plans for COMSEP***

COMSEP Strategic planning for 2004 and beyond.

As I noted earlier, the Executive Committee has been working on this for a few months, after we started collecting opinions and surveys last year. What follows is a draft of what has been developed to date. Parenthetically and in upper case are comments about the status of some of the proposals/initiatives. Please read this carefully and let me know how you feel about what you see. The document needs to be finalized, and ultimately it and the necessary by-laws changes will need your approval. This will happen by ballot so that we can have this ready for the 2004 annual meeting.

Please comment directly to me by e-mail or letter. Thanks for the help,

--Bruce

***Strategic Planning Summary and Action Plans***

**1. Mission Statement (THIS IS NEW)**

The mission of COMSEP is to improve the health care of infants, children and adolescents in North America by fostering excellence in pediatric undergraduate medical education.

COMSEP will advocate and provide support for:

- The development, implementation, and evaluation of high quality Medical Education programs
- Educational scholarship
- Collaboration amongst medical educators
- The dissemination of ideas and knowledge in undergraduate medical education (UGME)

COMSEP activities include:

- Educational Programs for members and other faculty who are charged with administrative oversight for UGME: curriculum, learning, evaluation & feedback, career counseling.
- Scholarship: Programs that foster research, education, and innovation in undergraduate medical education
- Career development: Support for personal and professional development

- Collaboration: Promote and foster collegial collaboration in educational programs, scholarship and career development

**2. Membership**

(A MEMBERSHIP COMMITTEE HAS BEEN FORMED TO TRY TO FINALIZE THESE IDEAS. LET ME KNOW IF YOU THINK THEY ARE WORKABLE OR WHERE CHANGES MIGHT BE NECESSARY.)

A. Standard dues per school: Amount to be determined by Executive Committee after review with AMSPDC Executive Committee and includes the Clerkship Director and two additional members only. One of these members will be the Delegate member of COMSEP and have voting rights for his/her school.

B. "Family" plan: Any additional members at the school *who have administrative responsibilities for medical student education in Pediatrics* (e.g., site directors, year one or two coordinators, year 4/SubI coordinator) are welcome to join COMSEP at an additional $30/person/yr, subject to nomination by their Delegate member and approval by the Membership Committee.

C. "Emeritus" or Honorary membership: Educators who have been active COMSEP members for greater than 5 years may be nominated for Honorary membership status. This description recognizes significant contributions to the COMSEP organization and/or significant achievement at a national or international level in the field of medical education. Honorary membership will usually, but not always, be reserved for members who are no longer directors of UGME at a medical school due to career changes or retirement, and remain actively committed to the goals and projects of COMSEP. Honorary members will pay a $30 annual administrative fee.

Process for nomination for honorary membership:

1. Any delegate member may nominate an individual for honorary membership.
2. Names will be submitted to the Membership Committee who will verify that the nominee meets the eligibility requirements and submit the names to the Executive Committee.
3. The Executive Committee will vote on honorary memberships at the Annual Meeting.
4. Individuals elected to honorary membership will receive a letter and a certificate from the President. They will be added to the list of honorary members posted on the COMSEP Web site and will be highlighted in the next issue of the Pediatric Educator.

D. Associate membership:
Educators not associated with an AMSPDC-member medical school may apply for associate membership in COMSEP, via the Membership Committee. Dues will be $30/associate member /yr (to be established by the Executive Committee).

E. Clerkship coordinators (administrative or secretarial personnel): (A LISTSERV HAS BEEN UP SINCE APRIL 2003.)

F. Osteopathic schools:
Representatives will be offered member-at-large status (non-voting) and will be assessed a $30/per person/year fee. (IF YOU ALL AGREE, I WILL NEED TO TAKE THIS BEFORE AMSPDC, AS THERE HAVE BEEN SOME ISSUES IN THE PAST.)

G. Voting:
For 2004 election – each school will get one vote. The Delegate member will cast the vote for their institution. The COMSEP President and Coordinator will get the proper people identified as balloting time draws near. The group will be

surveyed to determine if this mechanism worked after the 2004 election.

H. Database:

Data will be collected annually (actually twice a year) and will reside in the Web site. We need to track personal info, scholarly productivity, and perhaps some clerkship-specific info.

I. Membership committee:
(NOW CHAIRED BY CHRIS WHITE. THIS GROUP WILL FINALIZE MEMBERSHIP ISSUES IDENTIFIED ABOVE, DEVELOP DATABASE FORM, AND MAKE FINAL RECOMMENDATIONS TO THE EXECUTIVE COMMITTEE BY SEPTEMBER.)

**3. Structure**

A. By-laws:
(WILL BE REVISED AND CHANGES WILL NEED MEMBER APPROVAL.)

B. Task Forces
No change in current TFs. Leadership of task forces: the president appoints task force chairs, with the consent of the Executive Committee. Task Force chairs serve for three years, and may serve a second 3-year term. TF leaders who are not on the Executive Committee will be invited to all Executive Committee meetings at the discretion of the COMSEP president.

C. Membership Committee:
Organized and meeting by conference call and e-mail.

**4. Meeting/Work of COMSEP**

A. Reclaim a half day:
(WE SEEM TO LOSE SUNDAY MORNING TO TRAVEL); consider starting Thursday PM, end Saturday night with the social event. This can *only* work if PUPDOCC can still meet within these constraints.

B. Task Forces:
Meet twice. TF chairs will report work plans for coming year to President/Exec within a week of the end of the meeting. President will be responsible for working with TF leaders to make certain they stay on task.

C. Task Force leaders meeting:
This will take place the last day, just before the dinner.

**5. Collaborations**

A. Within COMSEP:
TF leaders will work with each other on collaborative projects within COMSEP

B. APPD:
TF leaders of COMSEP will develop liaisons with their APPD counterparts to develop collaborative projects and initiatives

C. APA SIG:
Current relationship is good. Keep the cooperation, but maintain separate identity (WILL CHANGE THE CURRENT COMSEP BY-LAWS).

D. Other groups/collaborative projects:
(KAREN MARCDANTE HAS AGREED TO CHAIR A GROUP ON "PROCESS AND PRODUCT." IDENTIFIED MEMBERS include Robin Deterding, Leslie Fall, Jose Gonzalez, Starla Glick, Ardis Olson, Jerry Woodhead, and Bruce Morgenstern).

**6. Money**

COMSEP Executive Committee will develop a plan to seek support.

**Revision of the APA Educational Guidelines**
Submitted by Richard Sarkin

I represent COMSEP on the Advisory Board of the Ambulatory Pediatric Association (APA) Education Guidelines for Residency Training in General Pediatrics Revision Project. These revised Guidelines will reflect changes in the science and practice of pediatrics, and contain a flexible and adaptable online version, including a

competency-based curriculum. Diane Kittredge from Dartmouth is the Project Director. Several members of COMSEP have been very involved with this project.

At the 2003 PAS meeting in Seattle, the most recent draft of the Guidelines was presented. Beta testers have already been recruited for the next phase of development. The final version of the Guidelines should be available at the 2004 PAS meeting in San Francisco. For the latest information on the APA Guidelines revisions, see http://www.ambpeds.org/guidelines/index.cfm.

***Hot off the Press!***

Announcing the Pediatric Clerkship Guide!
Jerry Woodhead

The Pediatric Clerkship Guide was published in June and is now available for students. It represents the work of 20 current and former COMSEP members (plus others) and is explicitly based on the COMSEP Curriculum. My contribution included development of the structure, selection of the contributors, writing and editing the chapters, developing cases and the multiple choice examination, and working with the publisher to make the book a reality. I was motivated to do this project because no similar book existed at the time I started (and as far as I know, still does not exist).

The COMSEP Executive Committee was supportive of my proceeding with the development of the book (I sought support since it was to be linked so closely to the Curriculum). As you also know, this book is NOT in any way a formal COMSEP "product." In the Preface I observe that the book was written by clerkship directors and other experienced Pediatric educators, and I comment that the book "covers" the Curriculum that is used in more than 90% of Pediatric clerkships in the US. In the Acknowledgments I emphasize the impact of COMSEP on medical student education and praise the expertise of Pediatric Clerkship Directors.

It is possible that I will receive some royalties from this book -- when and how much, I do not know. In addition, each of the contributors will (I don't believe that they have yet) receive a small honorarium plus a copy of the book. It is my intent to donate to charity at least the portion of royalties represented by the purchase of books by University of Iowa students. I do not expect to be able to retire (or even purchase a new computer) with the royalties.

Hopefully, the book is a work in progress. If you or your students find areas that are particularly useful or particularly not well done, please let me know. If there are future editions, the book will be made better with that feedback.

**Pediatric Education Steering Committee**
Submitted by Richard Sarkin

I am COMSEP's representative to the Pediatric Education Steering Committee (PESC), which has been charged with implementing the Future of Pediatric Education (FOPE) II Task Force recommendations

(http://www.aap.org/profed/fope1.htm).

Members of COMSEP will be working with PESC to help implement the recommendations that specifically deal with medical student education.

PESC functions under the auspices of the Federation of Pediatric Organizations (FOPO). More information about FOPO and PESC is available at the FOPO Web site (www.fopo.org). The April, 2003, FOPO Newsletter summarizes the most recent progress of PESC

(http://www.fopo.org/NEWSLETTER1.htm),

including ways for Pediatric Department Chairs to take leadership roles in implementing some of the FOPE II recommendations.

**Committee on Pediatric Education**
Submitted by Gary E. Freed

The Committee on Pediatric Education (COPE), is a Committee of the American Academy of Pediatrics. It consists of representatives from the principal pediatric organizations, and serves as a forum for discussion on key issues pertaining to medical education. COPE met in Chicago on July 20-21, 2003. A key focus at this year's meeting was international pediatrics and the extent that it will represent an important dimension of pediatrics in the U.S. in the next 5-10 years. The term international pediatrics was used in its broadest sense to encompass everything from the exchange of intellectual, research, and clinical ideas at the organizational level to the provision of clinical services in remote third-world countries. Representatives from Mexico and Europe were present to present their perspectives.

Another major topic of discussion was the new mandate limiting the hours that a resident can work, it's effect on resident education, and it's impact on fellowship programs. An interesting point was made that moonlighting does count towards the 80 hours per week that a resident can work. The inability to moonlight will put economic strains on many residents and they will be less likely to want to go onto fellowships, further straining the short supply of many subspecialties. On the topic of fellowships, the American Board of Pediatrics did NOT approve a change from 3 years to 2 years of general pediatrics before starting most fellowships.

Issues relating specifically to medical students were also discussed. An effort is being made to create a linkage between local Academy chapters and pediatric clerkships. A push is being made to allow medical students to join the AAP as a subset of the Residency Section of the Academy. An important change is that dues for students will be lowered to $15 (down from $30). The membership will provide an "electronic" subscription to *Pediatrics*, availability of the Academy's Grand Rounds, as well as access to Pediatrics 101 (check it out on the Academy's Web site). To promote this, the Academy plans to contact the local chapters and encourage them to develop a joint activity with the Clerkships in their area. The cost of activities such as a dinner or lunch with interested medical students will be reimbursed by the Academy. The Academy plans to contact the local chapters this fall.

***Task Force Committee Reports***

**Curriculum Task Force:**
The Curriculum Task Force met twice during the Annual Meeting in Colorado to decide the next steps for the task force. After a spirited discussion, the task force opted to establish benchmarks for the competencies outlined in the National Pediatric Core Curriculum. Members of the task force agreed to begin the process by reviewing the competencies in the COMSEP curriculum chapters: Skills, Chronic Illness, Common Acute Illness, Child Abuse, and Emergencies. Competencies would be classified as CORE or MASTER level. The task force agreed *not* to modify the competencies as they are currently written. Additionally, individual members of the task force agreed to monitor specific chapters of the National Curriculum and Problem Set for outdated, incorrect, or new information.

The Curriculum and Evaluation Task Forces met jointly on Sunday. The joint task force members discussed which competencies were unique to pediatrics and the link between assessment and curricular change. The group agreed to "pair" a member(s) of the evaluation task force and a member(s) of the curriculum task force to review the Skills, Development, Anticipatory Guidance, Genetics, Chronic Illness, Common Acute Illness, Child Abuse, and Emergencies chapters. The group would not only help define levels of competency but also potential ways of assessing those skills, attitudes, or behaviors with references to currently existing tools. This too is envisioned as an ongoing project.

--Bill Raszka

**Evaluation Task Force:**
The task force leaders explained to the membership the reasons for not pursuing last

year's proposed project that would have created and maintained a bank of MCQ questions and a bank of SP cases on the COMSEP Web site. The reasons were: 1. Initial set up costs and ongoing yearly expenses and effort to maintain these banks on the Web site would be substantial. 2. The cost benefit ratio to COMSEP members of the usefulness of MCQs and SP cases versus cost of the Web site. 3. The consideration that some of the MCQ questions might not be of high quality. 4. The fact that the majority of schools (>80-90 %) now use the NBME shelf exam. The task force members acknowledged their agreement with this decision and decided that posting a list of COMSEP members who are willing to share MCQ or SP cases would be inexpensive and useful to COMSEP members.

Dr. Mary Rimsza, the editor of the Pediatric Review and Education Self Assessment Program of the American Academy of Pediatrics, made a presentation about the AAP's PREP program and PediaLink, the AAP's Web site for CME. An archive of PREP Self-Assessment questions on CD-ROM is available that can be sorted by topic; many of these questions would be suitable for MS3 testing level. Mary will find out if there is any limitation on the use of these archived questions by clerkship directors. There was great interest among the members of the task force about the possibility of using these questions for quizzes, self-assessment and in-house examinations.

Roger Berkow gave an update about NBME. He is now Chair of the Pediatric Step 2 Committee. He explained the process by which the NBME develops and tests questions for inclusion on the exam. The Clinical Skills Assessment, which will be part of Step 2, will be launched in 2004 for the current class of 2005. Test Centers in Philadelphia and Atlanta are already up and running and the medical schools in those two cities have had students participate in pilots of the CSA.

Bruce Morgenstern (COMSEP President) gave a brief overview of a new project the NMBE is undertaking; the CJA (Clinical Judgement Analysis Project) which has had one meeting with Bruce and several with COMSEP members attending. Updates will be forthcoming, as more information about the direction this project will take becomes available.

The remainder of the first task force meeting was spent discussing a project for the coming year. The group decided to focus on the competencies in the COMSEP curriculum and define different levels of mastery for selected competencies. A decision was made to work with the curriculum task force on this project and define/specify a tool(s) whereby each competency might be evaluated.

The 2nd task force meeting on Sunday morning was a joint meeting with the Curriculum Task Force.

Bill Raszka summarized the work of the 1st meeting of the Curriculum Task Force.

The Curriculum Task Force had agreed to:

1. Review the competencies in the COMSEP curriculum chapters on:
   Skills, Chronic Illness, Common Acute Illness, Child Abuse, and Emergencies
2. Competencies would be classified as CORE or MASTER level;
3. A decision was made *not* to modify the competencies from what is already written.

Paula Algranati and Lindsey Lane highlighted how the curriculum and evaluation task force projects are congruent, with each one being the natural extension of the other.

**Joint project:**

The Curriculum and Evaluation Task Force members jointly discussed which competencies in the COMSEP curriculum are unique to pediatrics and, for which pediatric clerkship directors should therefore take both ownership of and responsibility for teaching and assessing medical students. The group felt that Development and Anticipatory Guidance were uniquely pediatric and should be addressed in the first phase of this project. The group agreed on the following plan:

1. To "pair" a member(s) of the Evaluation Task Force and a member(s) of the Curriculum Task Force.
2. To work on the "areas" of Skills, Development, Anticipatory Guidance, Genetics, Chronic Illness, Common Acute Illness, Child Abuse, Emergencies.
3. To define levels of competency and ways of assessing with references to currently existing tools.
4. To have a team leader for each "area" who will collect the work done by the curriculum/evaluation pairs.
5. To schedule a conference call(s) to discuss, edit and refine the materials submitted.
6. To have a timeline as follows:
   - "Pairs"& "area leaders" to be designated over the next month.
   - Work to begin in early May and submission by each "pair" to "area leader" in late June.
   - Team leaders and Task Force Co-Chairs to review the materials in July.
   - A draft summary to be sent to the entire group for review by the beginning of September.

**Faculty Development Task Force**:
The Faculty Development Task Force met on April 4 and 6 at the 2003 COMSEP meeting. We reviewed the accomplishments of task force members since last year's meeting, including several workshops and activities slated for this year. These included the "New Clerkship Directors Workshop," the mentoring program, and the "Lunch with the Experts." Workshops for this year included humanism, portfolio development, "mid-career" clerkship directors, and teaching residents to teach.

Discussions initiated last year about developing a curriculum for COMSEP members related to faculty development were continued. A working group to consider a "road map" was formed to identify themes and content for educators at several career stages, as well as to conduct a needs assessment of our membership. A related project will be a needs assessment of new COMSEP members, both related to the annual meeting and also to year-round activities.

Activities that would further promote inclusion of new members or attendees were discussed. The possibility of a pre-conference reception for new members, perhaps held after the New Clerkship Directors Workshop, was mentioned and will be brought to the Executive Committee. The status of the "resource manual" was discussed, with the possibility for reviewing and updating this on the Web site. This will be coordinated with the Technology Task Force.

The possibility of a more formal liaison with APPD was discussed. Several COMSEP members are also members of APPD. APPD has adopted a task force structure similar to that of COMSEP; this may allow for joint projects in several areas, particularly faculty development. Mimi Bar-on will serve as the liaison between our task force and the corresponding task force in APPD.

Steve Miller reviewed the status of the journal review activity, and is recruiting for reviewers and editorial board members.

Additional projects that were discussed for the upcoming year included the development of an educator's portfolio template, possibly for posting on the website, development of an evaluation system for workshops, with a mechanism for feedback and peer review and a poster/platform series on "State of the Art" or "Best Models/Best Practices" for innovative ideas in pediatrics education. The purpose of this would be to highlight good working models that are not necessarily "research-driven."

The 2004 meeting will be held jointly with AMSPDC, which provides an opportunity for discussions and workshops that address issues important to all. One suggestion was for a panel discussion, with both chairs and clerkship directors participating, on "expectations for the clerkship," possibly including topics such as how to recognize, protect, promote and reward education within departments, clerkship administration, etc. A pre-conference workshop on writing and on critically reviewing papers was

also recommended. Other workshop suggestions included teaching residents to teach, competencies across the curriculum, education as scholarship ("The Road Less Traveled"), problem faculty and faculty feedback, mentoring for mid-career management, "research" (study design, writing, qualitative research) and faculty leadership. Some of these topics may also have been discussed in the other task forces, and we welcome the opportunity to share ideas with our colleagues. It was felt that we should continue to encourage multiple presenters for workshops as a means to involve some of our newer members in the activities of the meeting.

--Steve Miller, Bill Wilson, and
Shale Wong

**Research and Scholarship Task Force**:
Our first action at this year's meeting was to rename the task force as The Research and Scholarship taskforce. We had a lively and productive meeting in Denver. We discussed three topics this year. First, we feel there is a need for a small grant program to promote research and scholarship within COMSEP. Our discussion focused on the specific needs of two different pools of individuals: those new to the organization and those individuals who have an established interest in educational research and scholarship. We understand that the logistics of obtaining funding, the specific flow of funds to individuals and the amount of the awards have yet to be decided.

We also discussed the need to better inform the COMSEP membership about the scholarly activities within the organization. An ideal media for this is the COMSEP Web site. In addition to the proposal that was submitted to the executive committee, describing the need for a searchable resource, our committee discussed other resources that should also be made available.

We chose nine abstracts that were presented at our annual meeting to be sent to *Teaching and Learning in Medicine* for their review and publication.

We discussed ideas both for workshops for next year's meeting and for collaborative research projects for the next year. We will focus on trying to complete two systematic reviews on topics of medical education: teaching and evaluation of communication skills and teaching and evaluation of professionalism. We will set up regular conference calls throughout the year to facilitate this process. In addition, a subset of our task force will investigate the process of selection and responsibilities for Pediatric Chief residents.

--Sherilyn Smith and Cynthia Christy
Co-Chairs

**Learning Technology Task Force (LTTF):**
Improving learning with the use of technology is the focus of the LTTF. We always start our meeting sessions by reviewing new developments in the area of technology/learning and sharing interests. New developments discussed related to key hard drives (a great cheap gift for techies!), organizing clerkships on-line, and PDA discussions – there are real cool things happening out there! The COMSEP Web site was also reviewed. The number of Web site hits has steadily increased from 100 to 150 a day over the last year. The most active areas include: curriculum, educational resources, scholarly activities, and the annual meeting. Furthermore, we discussed the successful EBM preconference and PDA workshop offered at the meeting by LTTF members.

Exciting plans for the upcoming year were then discussed and developed.

1. COMSEP 2004: LTTF members felt a PDA session was still of interest. As we had an in-depth discussion in the LTTF related to ways to organize clerkship material on-line, a workshop to review options and share experiences will be developed for all members. Taking the lead on a PDA session will again be Pradip Patel, Kathy Previll, and Mark Hormann and organizing the clerkships on line will be put together by an interested group to include: Norm Berman, Bob Drucker, Ted Sectish, and Mike Bourgeois.
2. Technology tips: Chris White expressed interest in putting together information related

to quick tech tips for COMSEP members. If you have a quick tip send it to Chris and he will get it out.

3. COMSEP Plenary streaming video: Mark Hormann and the University of Texas, Houston Medical School have graciously agreed to stream future plenary talks. LTTF will help video the sessions if it cannot be arranged as part of the meeting.
4. Web site activities: LTTF members would like to see member profiles with areas of interests and search functions related to the community. Plenary streaming video will be linked from the Web site. CLIPP access will continue to be linked from the Web to provide access to Web-based cases.
5. A list of LTTF member's area of interest and expertise was developed. Pradip suggested that perhaps these areas of interest should become small subcommittees to the LTTF and provide updates at the meeting. Great idea! I took the liberty to create the following subgroups.

    A. DistantLearning/Web-based learning: Robin Deterding, Scott Davis, Michael Bourgeois, Mary Ottolini, John Vandermeulen, Ted Sectish, Bob Drucker,
    B. Multimedia resources and development: Chris White, Keith Boyd, JoAnn Harris, Phil Kaleida, Mary Ottolini, David Levine
    C. PDA: Scott Davis, Kathy Previll, Jerry Stirling, Pradip Patel, Mary Ottolini, David Levine, Chris White
    D. Research using technology: Chris Maloney, Robin Deterding

As you can see the LTTF is an active and energetic group! Please let us know if you would be interested in any of our projects for 2004 and use our interest groups as a resource.

--Robin Deterding

(A big thanks to Chris White and Chris Maloney for helping facilitate the LFFT at the 2003 meeting.)

***More on CLIPP***

The original CLIPP project is entering its final phase, and it is exciting to see so many cases on the Web! It is hard to believe that just three years ago CLIPP was only an idea. We sincerely thank all of you who have made CLIPP into a reality. By the end of July there will be 24 cases posted and available for your students to use. We hope to have the remaining 7 cases available by September. Peer review of each case is ongoing and we expect that all cases will have been peer reviewed by the fall. Thank you to those of you who have already served (or will soon be serving) as reviewers. We are very pleased that 42 of COMSEP schools have asked for access for their students. If you haven't signed up yet and would like to, send us an e-mail at:

clippcases@mac.dartmouth.edu.

Please remind your students to fill out the on-line evaluation form at the end of each case and let us know what they think.

The good news continues with the announcement that we were awarded a continuation grant for CLIPP from HRSA, beginning July 2003 and continuing through July 2006. This new award will allow us to refine the cases further and to develop the resources you need to help integrate CLIPP into your clerkship, including a password-protected site for final exam questions, an on-line search function and additional teaching material to use in conjunction with the cases. We will also be fully integrating CLIPP into 6 COMSEP schools in order to formally study effective ways to integrate computer-assisted instruction, as well as studying the impact of the cases on how students learn. Lastly, we will be developing three new teaching modules on contemporary issues that will complement the current cases: cross-cultural care, genetics, and care of children with special health-care needs.

We are excited to begin this new phase and we look forward to working with many more of you over the next three years!

--Leslie Fall and Norm Berman
CLIPP co-directors

***Technology Tips***

What do "jump," "key," "pen," and "flash" all have in common? The answer is that they are all names for a fabulous new way to carry and transfer information and files from one computer to another. These devices are about 3-4 inches long, 1 inch wide, and less than 1/4 inch thick. They plug into the USB port on your computer (any PC or Macintosh computer that's made within the past 5 years should have a USB port). They can hold up to 1 gigabyte of information, depending on how much you are willing to pay. A quick perusal of the Web shows that you can get a 128MB key drive for around $35. You can go on eBay and do even better, and the prices will likely continue to drop in the future.

These devices make the need for a floppy drive obsolete, and you won't need to burn CD's to transfer files either. Additionally they are much faster. And what is even better, if you have a Macintosh or a PC running Windows 2000 or XP, you don't need any special software. You just plug the key drive into your computer's USB port, and it recognizes it immediately. Just copy your files to it just like you would to a hard drive, floppy, or CD. Then you can remove it and your files are saved, ready to be loaded to another computer. The only caveat is that if you have a computer running Windows 98, you need to load a special driver when you first use it so that your computer will recognize the drive. These are usually available for a free download on the Internet from the Web site of the maker of your key drive.

How do you use these? If you have more than one computer, it's a great way to transfer files quickly and easily. Since Microsoft Word, Excel and PowerPoint files are completely compatible between Macintosh and Windows, you can transfer these files easily between these two platforms. For meetings, you can put PowerPoint presentations on them and then upload it to another computer for giving your presentation (great for travel!).

These devices are remarkably convenient and simple to use. How much memory do you need? I would recommend a minimum of 64 MB, with 128 to 256 being ideal. The best deals are on eBay or an online computer store, such as PCMall or Tiger Direct. Search the sites using either "Key Drive" or "Pen Drive."

--Chris White, Technology Task Force

***Other new Technologies***

**Video Otoscopes For Teaching Otoscopy**

Woodson Scott Jones, Christine L. Johnson, Jeffrey L. Longacre, Department of Pediatrics
Uniformed Services University of the Health Sciences (USUHS)

Several recent studies have identified deficiencies in the otoscopic diagnostic skills in some pediatric providers and residents.[1,2] On an end-of-clerkship survey, 45% of our USUHS third-year medical students reported they could not make a "reasonable" otoscopic assessment in young children's ears more than half of the time.[3] Traditionally, teaching of otoscopic skills has relied primarily on repetitive examinations accompanied by didactic sessions. Some educators have incorporated various other modalities (VHS, CD, Web-based), which utilize video images of tympanic membranes. While these interventions should improve diagnostic skills, they may fail to adequately address examination skills and provide feedback in a clinical context. When a student looks through the preceptor's otoscope, any movement of the otoscope or the child, removes assurances that the student is seeing what the teacher intends. Dual-headed otoscopes have inadequate magnification and are quite challenging to use in young, uncooperative children.

**What is a video otoscope?**

A video otoscope (VO) utilizes endoscopic technology to acquire and project video images of the tympanic membrane onto a monitor for preceptors, patients, families, and learners. The instrument takes the ear examination out of the proverbial "black box" and into the "light" for all to see and discuss. These devices have primarily been utilized by veterinarians, audiologists, otitis

researchers, and in telemedicine. Kaleida and Hoberman utilized a VO to acquire images of tympanic membranes in order to develop the Video Otoendoscopic Examinations to both assess and train providers in otoscopic interpretive skills.[4]

**What equipment is required to perform video otoscopy in children?**

The components of a VO platform necessary to capture images in young children of sufficient quality for teaching and/or management of ear disease include pneumatic capability, small speculum compatibility, wide depth of field (ranges at which a well-focused image can be maintained), and recording capabilities. Because many VOs were designed for adults, they do not have the capability to perform pneumatic otoscopy, a critical element of the pediatric examination. In order to obtain images in younger children, 3mm (2.5mm is even better) speculum compatibility is essential. Due to children's smaller, often cerumen-occluded external auditory canals, larger sized speculums will prohibit acquisition of images of the tympanic membrane. A high resolution video camera with a wide depth of field, along with recording capabilities (VCR, CD, DVD) is important due to the need for quick acquisition of images in young children and efficient retrieval of the recorded video images for teaching. Video recording is far superior to static imaging because of the added essential element of pneumatic assessment. It is also best to have a recording mechanism that allows immediate retrieval and ease of multiple replays because of the brevity of the video segment acquired. Hence, video digital images (CD or DVD) are more practical and they offer higher quality images.

**How to use video otoscopes to teach students/residents.**

In order to more accurately assess the students' diagnostic skills, it is best to have the student present their ear findings with specificity such as using the COMPT mnemonic (Color, Other, Mobility, Position, Translucency).[5] If there are otoscopic findings of interest, it is more efficient to bring the patient to the VO than vice versa. Therefore, if possible, set aside an examination room with the VO and recording equipment as the "ear room." After acquisition of an image, replay it for both the student and family for teaching. The video images are saved and available to teach other students who may have been with different patients. In our experience, both students and parents highly praise the use of this technology. We are currently assessing whether this intervention improves otoscopic diagnostic skills.

**Brief Review of Video Scopes**

*Welch Allyn Compac Video Otoscope –*

This relatively inexpensive and easy to use handheld, stand-alone unit, has a battery powered light source. It is compatible with most monitors, TVs, and VCRs. It has limited utility in young children due to the lack of pneumatic capability, low luminance when smaller specula are used, narrow depth of field, and it is awkward to hold this instrument in a vertical plane that is necessary to keep the projected image in proper orientation.

Though there are many video otoscopy platforms available, very few have pneumatic capability. *JEDMED* and *AMD* make video otoscopic platforms that have pneumatic capability, broad depth of field, and utilize smaller speculum sizes with adequate luminance. These platforms can be very expensive (>$10,000) once a complete VO platform is assembled. However, more economic but less complete VO platforms with pneumatic capability are on the horizon, but to our knowledge, lack reported utilization in young children.

**Want more information?**

For more information about Video Otoscopy, read the Alaska Native Health Board report on video otoscopes http://appliedsci.uaa.alaska.edu/nlm/otoscope.pdf and/or the following video otoscopy Web site http://www.rcsullivan.com/www/ears.htm. A schematic of the components of a VO platform is available online at http://www.rcsullivan.com/www/vosysc2.htm (Please note this schematic is outdated lacking the use of DVD recorders to convert analog images to digital.)

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## ***Literature Review***

*Once again Steve Miller and a host of COMSEP members have done an outstanding job reviewing and summarizing the literature.*

Pediatric Educator: Journal Review

Welcome to our ninth 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)

We will also be publishing this on our Web site. 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. I have purposely posed these as "Yes or NO" questions – so we can see the landscape of our behaviors.

We are also planning to expand the journals we cover to include what is written about in other fields – such as internal medicine. So – our first question for discussion is:

**Which other journals – besides those listed below – should we be scanning for studies and ideas in medical education?**

**Pediatric Educator Journal Review : Vol. 5, No. 9, July 2003**
The staff includes anyone who has participated in reviews over the past 3 years.

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**1. Whither Bedside Teaching? A Focus-group Study of Clinical Teachers**
**Subha Ramani, Jay D. Orlander, Lee Strunin, and Thomas W. Barber *Acad Med* 2003 78: 384-390.**

**Reviewed by Randy Rockney, MD**
Brown Medical School

The authors study an all too familiar development in clinical teaching: diminishing time spent at the bedside with a shift instead towards conference rooms and corridors. The authors assembled four focus groups, all from a single department of internal medicine: 1) chief residents; 2) residency program directors; 3) skilled bedside teachers; and 4) other faculty. Audiotaped 60-90 minute group discussions were transcribed and analyzed using qualitative research methods.

The perceived barriers preventing bedside teaching centered around clinician lack of confidence with bedside teaching skills. Similarly, clinician educators shy away from bedside teaching because of the performance pressure they felt in the context of bedside teaching, almost as if the shadow of William Osler hung over every such encounter to the detriment of most of us. Other barriers to decreased bed or patient side teaching included the perception of the lack of value given to teaching in academic medical centers and an erosion of the teaching ethic.

Strategies suggested to reverse the trend of diminishing bedside teaching address the perceived barriers. Improving bedside teaching skills of faculty by allowing and encouraging faculty to accompany skilled bedside teachers on rounds is a novel and interesting proposition. Diminishing the aura of bedside teaching builds on the idea that all teachers had something to offer more junior learners at the bedside. As one focus group participant stated, "You can't get everything, but you can get more than you did as a third-year student." To enhance the value of teaching, focus group participants felt that senior faculty ought to be front and center teaching clinical skills. As one participant put it, "Teaching is the pinnacle of academic life...being a great diagnostician, to elicit a history no one else has elicited...great skills...equal to getting an NIH grant...that's the ethic one needs to create so that residents and students view that as a worthwhile goal."

Overall the authors strongly support bedside or, in the case of outpatient medicine, patient-side teaching and observing the development of clinical skills. Let's get away from the card-flipping, conference room seclusion that clinical medicine has too often become and back to the patients themselves.

*(It is amazing that insecurity – and not time - seemed to be the biggest barrier. That is great news – it puts the onus on us to be sure to tailor faculty development to these issues. The article includes a table that could serve as a great tool for suggesting how to organize excellent bedside teaching.*

*Do you run a session for residents or faculty on bedside teaching? Do you have students present patients in front of the family or patient? SM)*

**2. A Teaching Scholars Program to Develop Leaders in Medical Education**
**Steinert et al Aca Med 78(2) Feb 2003**

**Reviewed by: Angela M Sharkey, MD**
Assoc Prof of Pediatrics
Division of Cardiology
Washington University
St Louis Children's Hospital

This article is a review of the Teaching Scholars Program for Educators in the Health Sciences at McGill University. The goal of this program, which began in 1997, as stated in the paper is to develop leaders in medical education. The aims are to promote increasing expertise in developing

educational programs and assuming leadership roles in education. The program emphasizes four major themes: curriculum design and innovation, effective teaching methods and evaluation strategies, program evaluation, and research in medical education. The program is year long. The curriculum includes two university courses in the Departments of Education, Epidemiology or Management, independent study in the four major theme areas, participation in faculty-wide development workshops, a monthly seminar and attendance at a national or international conference.

Participants were expected to spend a minimum of two half days per week to meet these requirements. Funding from a private foundation covers the cost of the university course hours, travel to a meeting, and support for a research project. There is NO salary support provided. The faculty consist of three physicians and a clinical psychologist. To date, there have been 22 participants. This report covers the immediate and one year follow up feedback from the 15 course participants who had completed the program by September 2000.Scholars were from Departments of Medicine (3), Surgery (4), Family Medicine (2), Pediatrics (4), Anesthesia (1), and Otolaryngology (1).

There are no statistics or Likert rating information provided from the faculty feedback. Comments noted in the Evaluation and Discussion sections are overall quite positive. Faculty participants felt they were able to achieve their goals for the program. They felt they had a more structured approach to their teaching and learning and a better context for information presentation. Strengths of the program included advancing knowledge of curriculum design and adult learning theory, better small group facilitation, improvement of administrative skills, and networking (SOUNDS AN AWFUL LOT LIKE HOW I FEEL AFTER A COMSEP MEETING). The primary limitation observed by program participants was lack of time!

Eight scholars developed additional courses at their institutions based on their initiatives gained at the program. Eight presented the results of their projects at a national or international meeting. Two have published aspects of their independent study. Four designed research grant proposals that were funded. Six of the scholars developed faculty development workshops at their home institution, four conducted educational workshops at scientific meetings within their medical specialty.

Comment: This program offers an opportunity to participate in a structured Educational program with the goal of furthering careers of the participants and offering an enhanced construct for educational opportunities within the Department/Division of the participants. The program was perceived as a positive experience as best we can tell from the information provided. Certainly the achievement of funding for research initiatives and publications speak well for the program. It would be helpful to have rated feed-back for analysis rather than only written comment. There will be a need to evaluate participants on an ongoing basis to see if the changes/perceived value of the program is durable. Have any COMSEP members participated in the program ??

*(So – it seems that more programs are popping up to provide formal faculty development to nurture a core group of faculty that would be leaders in medical education. There are 3 types.*
*1. Formal outside programs with degrees attached – like USC, Southern Illinois, Michigan State, Stanford and Harvard MACY;*
*2. Internal Academies – UCSF, Harvard, Baylor; and*
*3. Informal – in house – programs – for everyone else.*
*Are you considering – or have you already partaken in formal training outside of you institution – like a formal education degree – or a certificate from an outside program – like the Harvard Macy program? Do you have access to a faculty development program at your institution, which provides support to become a bonafide medical educator? Do you think you would participate in a program like this, if you did not receive any salary support? Do you think*

*that all schools should be developing an academy for teachers, in the model of UCSF, Harvard, Baylor etc.? SM)*

**3. 'Talking the talk': school and workplace genre tension in clerkship case presentations Lingard L, Schryer C, Garwood K, Spafford M, University of Toronto, Canada. Medical Education 2003;37:612–620**

**Reviewed by: Bruce Z Morgenstern, MD**
Mayo Medical School

This article addresses the socialization of the medical student into the academic medical community, focusing on learning this community's "sanctioned ways of talking." The authors break down this talking into two broad categories, talking with patients and talking about patients. This study focused on the latter. The study is based upon genre theory, the genre being case presentations. In this case, the genre is used for dual purposes: patient care and for student evaluation.

To answer the question how (and how well) does the learning facilitated by the case presentation genre socialize the novice into the values and goals of a health profession discipline, the authors used a convenience sample of 11 students and 10 faculty. They observed and recorded16 oral case presentations and the teaching exchanges related to them, and conducted interviews. The interviews consisted of scripted open-ended questions about the nature and purpose of case presentation and two video clips of presentations, one of which was early and flawed and the 2nd was later and more sophisticated.

Not surprisingly, the students viewed the presentation as both an opportunity for learning, but also as an exercise on which they were to be evaluated. Students described the ideal presentation as one that did not get interrupted. Three strategies by students were identified: proving competence, seeking guidance (i.e., asking the staff how to proceed through a presentation), and deflecting criticism.

The faculty, on the other hand, felt that the presentation was a way to construct shared knowledge about a patient case, and to facilitate care. Faculty feedback was often explicit and comprehensive. Five important dimensions of an ideal presentation were uncovered: access to necessary information, reliability, relevance (or pertinence), evidence (as in EBM), and managing the probabilities (described as the "connection between populations and indices of diagnostic suspicion").

The different expectations of students and staff add to the tension between the need for a comprehensive presentation of all the information obtained and the need for an efficient presentation for diagnosis and management. Faculty often provided feedback on the presentation as a workplace genre, while students are often presenting as a school genre.

The authors conclude that "school and workplace iterations of the case presentation genre may be at cross-purposes," and that "when students and teachers perceive a genre differently, a 'gap' is created in their interactions." As a solution, the authors suggest that faculty review with students the multiple uses for the case presentation and explore with students the significance of these uses.

Comment: This study is an excellent example of the use of qualitative research to address an issue. One of the advantages of this form of research is that subject numbers can be small. Another is that a research question for a prospective study can be determined. This study opens many doors to improve the teaching and learning of an important skill.

The results are not surprising, but the data have not been obtained prior to this, nor have the competing perceptions of students and staff been addressed. The authors' solution requires some integration between clerkships. Students need to be able to be skilled in presentations for all clerkships, but the target (i.e., the "ideal") needs to be made obvious and relatively consistent. Is this a feasible goal?

*(Do you have consensus among your faculty and residents on what makes a good presentation? Do you have an explicit template for the components of a presentation that go beyond "SOAP"?SM)*

**4. Pangaro L, Bachicha J, Brodkey A, Chumely-Jones H, Fincher RM, Gelb D, Morgenstern B, Sachdeva A. Expectations of and for Clerkship Directors: A Collaborative Statement from the Alliance for Clinical Education. Teaching and Learning in Medicine 2003;15(3):217-222.**

**Reviewed by John S. Venglarcik, III, MD;** Tod Children's Hospital in Youngstown, Ohio and the Northeastern Ohio Universities College of Medicine.

Description: The Alliance for Clinical Education (ACE), a collaboration of national clerkship organizations, attempts to establish some standards "for what should be expected of a clerkship director" and to provide "guidelines for the resources and support" to be afforded the clerkship director. Their recommendations fall into five separate categories: (1) a job description and duties for the clerkship director, (2) qualifications for being a clerkship director, (3) resources necessary for the support of the clerkship, (4) career development for the clerkship director and (5) time allocations necessary for the clerkship director to fulfill their responsibilities. This is accomplished by establishing a rationale and defining essential and desirable elements for each of the above five categories.

The job description is detailed and recommends 11 specific or essential products for which the clerkship director is responsible and another five products that are desirable although not mandatory. The essentials include responsibility for the entire clinical experience from goals and objectives to performance expectations, handout materials, schedules, testing, grading, remediation, self-appraisal and assistance to students in matters of career guidance. The desirables include a defined reporting relationship as regards student performance and program effectiveness, budgetary responsibility and involvement in various educational assessments (e.g. faculty development and promotion) as well as resource allocation.

The essential qualifications of a clerkship director include nine elements: vision, knowledge of curricular goals, clinical experience, prior experience with medical students, communication skills, enthusiasm, experience in providing career guidance, and management skills and abilities. The desirables are prior clerkship experience, demonstrated teaching excellence, networking capabilities, motivational skills, feedback and advisory experience, and intellectual curiosity.

A rationale is provided for a set of essential resources available to the clerkship director which include control over resources sufficient to meet the needs of the clerkship, personnel (administrative and clerical), material resources, dedicated time, adequate space and access to new technologies. In the desirable category the most important resource is additional time; time for research, faculty development, and involvement in various committees.

The clerkship directors must be valued for their contribution to achieving curricular goals. As a consequence it is essential for career development that the clerkship directors be recognized for their educational productivity as well as given the time and resources necessary for continued development as both a clinician and an educator (including participation in faculty development). It is desirable that the clerkship director enjoys the benefits of a mentoring relationship, has the opportunity to assume other leadership positions, develop educational research expertise and serve on relevant school and national committees.

Finally, an appropriate amount of dedicated time necessary for the clerkship director to be successful is recommended. It is strongly suggested that 50% of a full-time equivalent be allocated to the clerkship director and that 25% should be considered the bare minimum.

Discussion: As someone who has been "in the

trenches" as a pediatric clerkship director for 19 years and more recently, as associate dean, has assumed a supervisory role that includes budgetary oversight for five other clerkships on our campus, I was delighted to read this article. The first thing that I enjoyed was the attempt of the authors to define a raison d'être for the huddled masses of clerkship directors. Their vision of the role of the clerkship director contains elements familiar to all of us; supervision, course content, evaluation, feedback, and self-assessment. It also sees the role of the clerkship director extending to curricular reform, educational research, faculty development, and promotion as well as to assuming a greater fiscal responsibility. In elaborating this vision they have not ignored the other reality; that of personnel management, resource accrual, and allocation, faculty retention, program assessment and time commitment. Furthermore, they have attempted to delineate a set of skills, attitudes and abilities necessary for success and the attainment of personal satisfaction.

I would recommend that anyone who reads this should read the original article. I would encourage one to compare the specifics of each recommendation to their own position. The recommendations are specific enough to make sense to an old veteran like myself but general enough to be applicable to a variety of clerkships regardless of type, location and format. The time allocation recommendations appear to be based on a consideration of the available literature but 50% of an FTE seems unrealistic, especially in circumstances such as my own where there are multiple sites with multiple clerkship directors for each required clerkship and the school consequently provides some support functions. In conclusion, I think it is a laudable effort that provides a framework to which clerkship directors from a variety of settings can begin to compare themselves as it relates to job description, qualifications, support services, and personal growth opportunities. It should also serve to establish benchmarks each one of us can refer to as we continue to fight for available resources.

*(Wow – I agree – we should all read this – Jon has been provocative in his comments on 50% support. Do you receive 50% support? Do you believe that less than 50% support is adequate? Do you believe this document would sway your Dean or Chair to change your support in any way? Does your institution have uniformity of resources and job descriptions across departments? SM)*

**5. Borleffs JCC, Cursters EJFM, van Gijn J, ten Cate, OTJ. "Clinical Reasoning Theater": A New Approach to Clinical Reasoning Education. Acad Med 2003: 78:322-325.**

**Reviewed by: Karen Marcdante,**
Medical College of Wisconsin

This interesting article describes a formalized methodology that is used in the authors' medical school to aid in teaching basic science students about clinical reasoning skills. The method is quite simple and all the more exquisite because of this. Creating two "scenes" in which the action takes place, faculty members interview a real patient (scene 1) then take a "timeout" to describe their thinking and interact with the students to decide on the next questions to ask or actions to take (scene 2). It is a dynamic process, oscillating between the two scenes. The method can be used for history-taking, physical examination, ordering and reviewing diagnostic tests, and providing therapeutic interventions. Actively involving the students holds their attention and, if reflection is added, should help them identify their own skills and gaps.

In reviewing this article, I would like to go back to a format we used when thinking about an evidence-based journal club. We used three questions to decide whether to review an article. The first question is about impact – does this affect learning? While the authors of this study don't measure impact at all, I can see where this method would lend itself to investigation. The clinical reasoning of students could be measured before, during and after this intervention. I'd also be interested in hearing about whether the clinical faculty at this institution think the students arrive

better prepared and more skilled in the clinical reasoning process since using this format. The second question asks whether the article focuses on a common problem. My answer is absolutely. I know that in the last few years, the whole concept of how we explicitly teach clinical reasoning has become increasingly important to me. Patients are with us for such a short period of time that we are more concerned with making sure we get things done than in explaining to the novices we have the privilege of trying to teach. The third question deals with change. If the article shows an affect on learning, could it change your practice? Once again, I would have to answer in the affirmative. Many of us are faced with escalating time pressures and some are struggling with patient numbers. In addition, if you think about patient safety and trying to allow learners to practice more in settings where patients are less at risk, this is a wonderful model. First, as the paper points out, more students can experience this type of demonstration than can comfortably fit around a bed. What they don't mention, and what may very well be equally advantageous is that one or two faculty members could focus on this type of training, freeing up others to deal with those patient care and time pressures.

So, for anyone struggling with how to teach this vital skill, how to improve efficiency, or how to stretch patients or faculty, this is a paper to read. I know that I have already thought about how to incorporate something like this in our clerkship, making sure to also look at the impact and evidence of its effectiveness. Being involved in fourth year student education, this article also gave me a great idea for a selective that could focus on integrating basic and clinical sciences without overwhelming faculty members. If anyone else has similar interests, I'd be happy to figure out a collaborative study comparing and contrasting variations on the model. It is a thought-provoking article and, with the likely diffusion of the ACGME competencies into our clerkships, a timely one addressing patient care and medical knowledge.

*(This is a great follow up to having George Bordage with us at the last meeting. The challenge is – how good are the faculty in thinking out loud – and in describing their strategies of reasoning? Do you have a seminar on clinical reasoning in your clerkship? How do you measure clinical judgment in your medical students? SM)*

**6. Academic Medicine, 2003; 78:491-496 From Case–based Reasoning to Problem-based Learning by Eshach, H and Bitterman, H.**

**Reviewed by Kathleen V. Previll, M.D**
The Brody School of Medicine

Eshach and Bitterman disagree that problem-based learning has not been proven to improve the knowledge base and clinical performance of medical students as measured in a review by Colliver. The authors feel there are inadequate curriculum assessment research tools to make such an assertion and go on to compare the learning process of case-based and problem-based learning with traditional medical school curriculum approaches.

They propose we use three types of reasoning to solve medical problems: (1) rule-based reasoning which presumes logic and is presented in the formats of lectures, or text book reading, (2) personal knowledge which they equate to anecdotal reasoning, and (3)case-based reasoning which presents the learner with a memory of richer contextual reference and allows the learner to propose solutions which may be novel to the learner.

The authors clearly favor case-based/problem-based learning and declare that this form of learning is more efficient, provides an index of reference for the student and allows the learner to use operational thinking as opposed to abstract reasoning to problem solve.

Finally the authors feel the trend to test medical students on exams such as the USMLE using clinical cases might serve students taught in case-based and problem-based formats especially well.

*(There is a great description of case based teaching – and a table that sets out the principles of excellent case based teaching. The key here is quality – excellent cases – which build on each other, compare and contrast to each other to highlight points of similarity and departure and which highlight actions and behaviors – teach reasoning – by demanding decisions.*
*Do you have case based teaching in your clerkship? Do you believe that case based teaching – in which you suggest models of reasoning – is superior to PBL – in which the learners develop their own models? SM)*

**7. "A Model of Determining a Fair Market Value for Teaching Residents: Who Profits", Cullen, EJ, et al, Pediatrics 112: 40-48, 2003**

**Reviewed by: William G. Wilson, MD**
University of Virginia

In the current economic climate of most teaching hospitals and medical schools, there are efforts to try to define the "cost" of medical education, both for undergraduate (medical) students and also for residents and fellows. This is further complicated for teaching house staff, since the institutions receive payment for having the residents, and the residents can engage in revenue-generating activities for the institution. The authors of this study, primarily intensivists and anesthesiologists, have attempted to devise a model for determining a "fair market value balance" for teaching activities in their unit. They define and derive several "return on investment" scores, favoring the CMS, the intensivists, and the residents, respectively, and compare the results in several different scenarios of increasing support for graduate medical education. They could not find a "balance point" at which these potentially competing interests were equal, although this would have been approximated if the direct medical education reimbursement were increased from their figure of 29.36% to 36%.

The authors provide an interesting analytical approach to trying to dissect the expenses and financial value related to medical education on a clinical service. While they state that their model "can be generalized to other resident teaching situations," I would be cautious to embrace this without careful study at other institutions and on other types of pediatric services. There are major differences within pediatric teaching services, and a model for PICU teaching may not translate easily to other settings.

*(Well worth reading – provides a way of modeling the cost and benefit of having trainees. What are your thoughts on the "added value" of students to the clinical service?*
*Overall, do you believe that third year medical students enhance the patient care and experience in your institution?*
*Do you believe that training medical students adds more than 20% to the work load of the responsible MD?*
*What percent of added work does being responsible for a medical student incur? Outpatient? Inpatient?*
*Does your school or department have a way of quantifying the efforts of faculty to teaching that is tied to a specific dollar amount? SM)*

**Other Studies (Reviewed by Steve Miller, MD – Columbia University/ Children's Hospital of NY):**

1. **Davis N et al, Treatment of medical students during clerkships based on their career interests. *Teaching and Learning in Medicine,* 15(3) 156-162**

Another example of simple qualitative research – (simple doesn't mean – easy – or not labor intensive) – answering an important question. Students feel pressured and admit to lying about their choices. They believe their experience changes – based on the answer. Interestingly – they don't recommend keeping it secret – or having a "don't ask" policy for faculty. Rather – they make suggestions of how to make it less high stakes to have the right answer.

*(Do you ask students to identify what they are planning to go into?*

*Do you counsel faculty and residents in this area – if yes – what do you recommend? SM)*

**2. Slavin S et al (Yes – our Stu Slavin) Curricular Reform of the 4th Year of Medical School, *Teaching and Learning in Medicine,* 15(3) 186-193**

This is a terrific description of educational innovation – that reforms the 4th year – and creates additional sense of connectedness among students. Interestingly, Stu describes how the colleges could actually promote diversity of training – rather than early specialization. Students who know they are going into primary care – may choose to joint the acute care college – as they might perceive that this is their last chance to get extra training in this area.

*(Do you have a structured career oriented approach to the 4th year at your school?*

*Do you think 4th year should be almost exclusively elective?*

*Do you think 4th year should have a limit to the number of specialty electives that can be done – eg. No more than 2 electives in any single surgical subspecialty? SM)*

**3. Deloney L, The ICM Pin: A Symbol of Professional Development, *Teaching and Learning in Medicine,* 15(3) 215-216**

This is a brief description of the power of a symbol to remind people of an important commitment to professional behavior.

*(Do you remember a specific event or symbol as having an important role in your behavior and identity?*

*Do you support these kinds of symbolic gestures as a way of promoting professionalism and humanism? SM)*

**4. Beagan B, Teaching Cultural Awareness... Ultimately it Makes No Difference, *Acad Med,* 2003; 78:605-613**

This is a frank description of a first and second year course – aimed at developing social awareness. It has a great discussion of the competing mindsets of medicine – the detached, impartial scientist vs. the emotionally aware practitioner. Worth reading for the thoughtful description of these competing tendencies and for how you might evaluate the impact of this type of teaching.

*(Do you believe that self awareness can be taught? SM)*

**5. Crandall S et al, Applying Theory to the Design of Cultural Competency Training, *Acad Med,* 2003; 78: 588-594**

Interestingly enough here is a competing study demonstrating the efficacy of a theory driven approach to a longitudinal course. The key here seems to be "theory driven" and the frameworks are neatly provided in a table for review.

*(Are you familiar with models of cultural competence – or cultural humility – as some suggest that this is a better term?*

*Do you teach "cultural competence/humility in your clerkship in a formal way? SM)*

**6. Newell G et al, Listening to Music; Teaching Medical Humanism, *Acad Med,* 2003; 78: 714-719**

This is a fun article to read – similar to Art and Medicine – it has a great outline of musical pieces that are relevant to medicine and how they are discussed. Only 36% of residents thought it would make them a better doctor (you could say – wow – 36% felt they would be better doctors for this – also) – but 94% enjoyed the experience and 70% felt they developed insight into the patient's world.

*(Do you think these types of experiences should be part of every third year curriculum? SM)*

**7. Hatem C, Teaching Approaches that Reflect and Promote Professionalism, *Acad Med,* 2003; 78: 709-713**

This article echoes the words of Larrie Greenberg – who always says that one way to promote professionalism in patient care is to assure that

students and trainees are well taught in humane environments. Hatem outlines a course to teach residents to be great teachers and to assure bedside teaching is done regularly. Useful as an outline of faculty development.

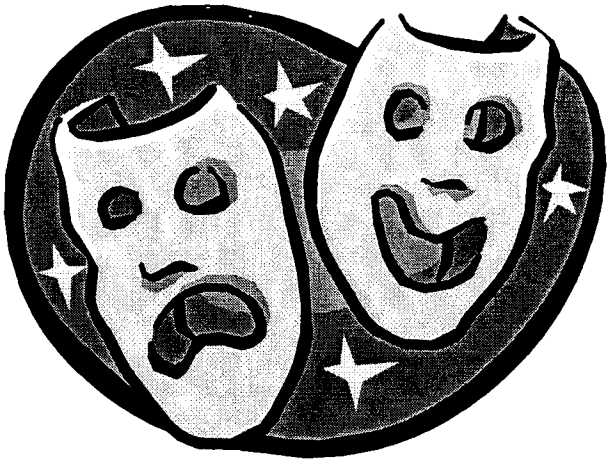
*(Do you have a formal curriculum for training residents as teachers? SM)*

**8. Watson R, Rediscovering the Medical School, *Acad Med,* 2003; 78: 659-665**

Must reading for everyone – if we are to be involved in education at the school and departmental level – and not just at the clerkship level. Watson suggests creation of core teaching faculty, change from departmentally based organization of teaching, salary that matches work – with a question of whether one should be paid as a neurosurgeon – if they are 50% teaching neurosurgery, and considering creation of education centers or academies.

It lays out the controversial decisions that will get made that may change our environment dramatically – so we need to weigh in.

*(Do you believe that your salary for your teaching time should be at a lower rate than for your clinical work? SM)*



*After all of that deep thinking, it's time to close with a little humor.*

**School Absence Excuses from parents (supposedly)—including spelling**

*My son is under a doctor's care today and should not take P.E. today. Please execute him.

*Please excuse Lisa for being absent. She was sick and I had her shot.

*Dear School: Please ekscuse John for being absent on Jan. 28, 29, 30, 31, 32, and also 33.

*Please excuse Gloria from Jim today. She is administrating.

*Please excuse Roland from P.E. for a few days. Yesterday, he fell out of a tree and misplaced his hip.

*Please excuse Jim for being. It was his father's fault.

*Carlos was absent yesterday because he was playing football. He was hurt in the growing part.

*Please excuse Ray Friday from school. He has very loose vowels.

*Please excuse Tommy for being absent yesterday. He had diarrhea and his boots leak.

# COMSEP EXECUTIVE COMMITTEE 2003-2004

**PRESIDENT** (2002-2004)
Bruce Z. Morgenstern, MD
Mayo Clinic
Mayo Medical School
200 First Street SW
Rochester, MN 55905
PHONE (507) 266-1046 FAX (507) 266-7891
E-Mail: bmorgenstern@mayo.edu

**PRESIDENT-ELECT** (2002-2004)
Steve Miller, MD
Dept. of Pediatrics, BH South 1-116
Babies and Children's Hospital
Columbia University
6522 W. 168th Street
New York, N Y 10032
PHONE (212) 305-8504 FAX (212) 305-3020
E-Mail: szm1@columbia.edu

**PAST PRESIDENT** (2002-2004)
Richard T. Sarkin, MD
Director, Pediatric Medical Student Education
Children's Hospital of Buffalo
State University of New York/Buffalo
219 Bryant Street
Buffalo, NY 14222
PHONE (716) 878-7288 FAX (716) 888-3966
E-Mail: rsarkin@upa.chob.edu

**MEMBERS:**

Paula Algranati, MD (2001-2004)
University of Connecticut Health Center
Department of Pediatrics--LG012A
University of Connecticut School of Medicine
263 Farmington Avenue
Farmington, CT 06030-3934
PHONE (860) 679-4960 FAX (860) 679-1251
E-Mail: algranati@nso2.uchc.edu

Leslie H. Fall, MD (2001-2004)
Clerkship Director, Pediatrics
Dartmouth Medical School
Dartmouth-Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756
PHONE (603) 650-5473 FAX (603) 650-5458
E-Mail: leslie.h.fall@hitchcock.org

J. Lindsey Lane, MD (2002-2005)
Department of Pediatrics
Jefferson Medical College
Thomas Jefferson University
833 Chestnut East, 3rd Floor
Philadelphia, PA 19107-5083
PHONE (215) 955-7800 FAX (215) 923-9383
E-Mail: jllane@nemours.org

William V. Raszka, Jr., MD (2002-2005)
Department of Pediatrics, College of Medicine
University of Vermont
Room A121 Given Building
Burlington, VT 05405-0068
PHONE (802) 656-2296 FAX (802) 656-2077
E-Mail: william.raszka@uvm.edu

Christopher White, MD (2003-2006)
Department of Pediatrics
Medical College of Georgia
HF-1121A, 1120 15th Street
Augusta, GA 30912-3770
PHONE (706) 721-3781 FAX (706) 721-3295
E-Mail: cwhite@mail.mcg.edu

William G. Wilson, MD (2003-2006)
Box 800386-Pediatrics
UVA Health System
Charlottesville, Virginia 22908-0386
PHONE (434) 924-2665 FAX (434) 982-3850
E-mail wgw@virginia.edu

**EX OFFICIO**

Gary Freed, DO (AAP COPE Representative)
Egleston Children's Hospital
Apnea Center
Children's Health Care of Atlanta
1405 Clifton Road
Atlanta, George 30332
PHONE (404) 315-2801 FAX (404) 325-6651
E-Mail: gary.freed@choa.org

Joan Fraser, MB, CB (PUPDOCC Representative)
Department of Pediatrics
University of British Columbia
Room 2D19 - 4480 Oak Street
Vancouver, BC V6H 3V4 CANADA
PHONE (604) 875-2882 FAX (604) 875-2890
E-Mail: jfraser@cw.bc.ca

**NOMINATING COMMITTEE:**

Richard T. Sarkin, MD (2002-2004)
Director, Pediatric Medical Student Education
Children's Hospital of Buffalo
State University of New York/Buffalo
219 Bryant Street
Buffalo, NY 14222
PHONE (716) 878-7288 FAX (716) 888-3966
E-Mail: rsarkin@upa.chob.edu

Mary C. Ottolini, MD (2003-2005)
Children's National Medical Center
Department of Medical Student Education
111 Michigan Avenue, NW
Washington, DC 20010
PHONE (202) 884-3938 FAX (202) 884-4741
E-Mail: mottolin@cnmc.org

Linda Tewksbury, MD (2002-2004)
Department of Pediatrics
NYU Medical Center
New York University
550 1st Avenue
New York, NY 10016
PHONE (212) 562-6430 FAX (212) 263-8172
E-Mail: lrt1@nyu.edu

rev 8/4/03

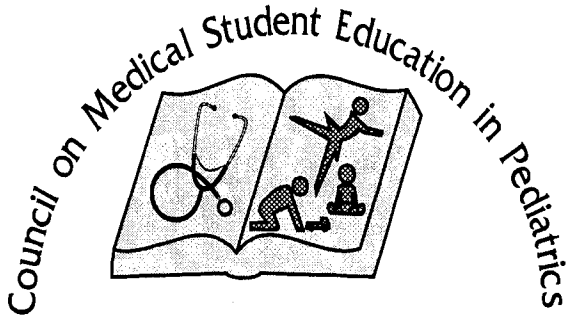
## *COMSEP ANNUAL MEETINGS*
## *UPCOMING DATES*

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

2005
Greensboro, North Carolina
April 7-10, 2005
Hosted by: Wake Forest University School of Medicine

2006
Salt Lake City, Utah
March 16-19, 2006
Hosted by: University of Utah School of Medicine

# The Pediatric Educator




**Volume 10 Issue 1** **Winter 2003**

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

*President's Message*
Bruce Morgenstern
Mayo Medical School
Mayo Clinic
Rochester, MN

New Year's resolutions: some personal and some for COMSEP

I never cease to be amazed at how I can lose track of large chunks of time. Here it is, Christmastime 2002, and I've been at this job nearly a year. When I accepted the nomination to be a candidate for COMSEP president, I did so because I thought I could make a difference. Well, 9 months later, I'm not sure I have. Lots of little things have kept me from focusing on the things I had hoped to do during my tenure. So, as we enter 2003, it's time for some New Year's resolutions: 1) I resolve to be more annoying. 2) I resolve to be more prompt. 3) I resolve to be a better advocate. 4) I resolve to grow hair. 5) I resolve to be more proactive. 6) I resolve to spend less (money and time) on my computer than in 2002. 7) I resolve to be better at providing students prompt feedback.

Hopefully, I will pull off #'s 1, 3, 5, and 7. If I'm lucky, 2 may come to pass. And if only 4 could happen! By the way, by "annoying," I mean that you will be hearing from me more as we try to keep COMSEP moving forward.

COMSEP can and will do the following:

1. We will complete our strategic planning. I will collate all the responses I received from the survey several months ago, and get the materials out to the Executive committee. The Executive committee will meet before the 2003 annual meeting and generate a mission and short and mid-term objectives for COMSEP.

2. We will continue to develop the COMSEP web site. We need to create a secure place for a question and case bank. We need to track our scholarly productivity and create an easily searchable resource for potential mentors, advisors, and collaborators. We need to make the site a truly useful destination.

3. We will develop and execute a plan to raise some funds. As supportive as the

chairs have been, we need additional funds to achieve some of the goals that members have outlined. This will require creative energy and lobbying from many members.

4. We will keep the curriculum process a living thing, so that we can keep up with the changing needs of students. The Curriculum and Learning Technologies Task Forces have been doing a great job of this, and we need to keep them energized.

5. We will continue to work with the Association of Pediatric Program Directors to make sure that we are doing those medical students who are interested in careers in Pediatrics a service as we advise them. We will continue our work with the NBME to make certain we examine students on concepts that are relevant and appropriate.

6. We will do more things, but I'm running out of space. The most important thing we can do is to continue to support each other and help each other have fun as we do our work. This to me is the greatest gift that COMSEP offers its members.

So, what else can we hope for in 2003? Well, COMSEP won't have much impact, but it would be wonderful to avoid a war. It would also be nice for the stock market to rebound, but somehow I doubt COMSEP will have much effect there, either. What I can promise is another great annual meeting, organized by Robin Deterding and Shale Wong in Colorado, with some help from Bob Janco and Nanette Bahlinger from Vanderbilt, and the usual irreplaceable support from Lisa Elliott and Jean Bartholomew.

I'm really looking forward to seeing you all in Colorado.

*Important announcements and updates for COMSEP members*

**Revision of the APA Educational Guidelines**
Submitted by Richard Sarkin

The 1996 *APA Educational Guidelines for 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 reflect a competency-based curriculum. Diane Kittredge from Dartmouth is the Project Director. Several members of COMSEP are involved in this project. A description of the progress of this update as well as the old 1996 version of the Guidelines is available at:
www.ambpeds.org/guidelines/index.cfm

**Pediatric Education Steering Committee**
Submitted by Richard Sarkin

I serve as COMSEP's representative to the Pediatric Education Steering Committee (PESC), which has been charged with implementing the recommendations of the FOPE II Task Force (see http://www.aap.org/profed/fope1.htm). Of all the 33 recommendations made in FOPE II Task Force Report (which also endorsed the 9 recommendations of the FOPE I Report), the Executive Committee of COMSEP decided that the following three recommendations were most important to our organization. We offered to help the PESC implement any of the FOPE I and FOPE II recommendations, but emphasized that these

three recommendations were particularly important to us:

FOPE II Recommendation #4:
"Pediatrics should take steps to enhance the scientific foundation of pediatric medical education and ensure that its programs (curriculum, teaching, and evaluation methods) are based on this science. Research centers for pediatric medical education should be established to develop and disseminate innovations in medical education, to collaborate with educators in other fields, and to enhance generally the profession's scientific knowledge about medical education. Faculty leadership in medical education should be encouraged."

FOPE II Recommendation #17:
"Medical student education should be centrally (not departmentally) supported at a level that will ensure innovative, comprehensive exposure for all students to the principles of child health care."

FOPE I Recommendation #6:
"All medical students should have a clinical experience of approximately equal length in pediatrics and internal medicine."

Members of COMSEP will be working with the PESC as the FOPE II recommendations are implemented.

**FOPO Subspecialty Forum**
Richard Sarkin

On 10/22/02, I attended a Subspecialty Forum in Boston sponsored by the Federation of Pediatric Organizations (FOPO). About 100 representatives of nearly all the major pediatric organizations and subspecialty organizations also attended this forum. The main topic was the American Board of Pediatrics' "Proposed Requirements for Subspecialty Training" (which can be accessed at: www.abp.org under the News section). Discussions included the suggested revisions of subspecialty training pathways, the requirement for "evidence of a meaningful accomplishment in research" for subspecialty training, workforce issues, and the recruitment of medical students and residents into careers in subspecialties. No decisions were made during the forum. More to follow.

At the forum, I emphasized that most members of COMSEP do a significant amount of career counseling to medical students. There is a need for careers in pediatrics to be portrayed as a wide spectrum of possibilities from the primary care practitioner to the quaternary care subspecialist, and all sorts of stuff in between. We need to be mindful of opportunities to have our students learn more about these various career possibilities.

**APA Special Interest Group: Medical Student Education**
Submitted by Steve Miller

This year we will be meeting in Seattle on Monday, May 5, 2003, at 9:00AM. The APA SIG is the second home of COMSEP members -- and the meeting usually has over 100 participants – including non–clerkship directors who participate in teaching.

This year, we will focus on defining humanism and professionalism and identifying and testing evaluation tools.

We will also continue to explore competency-based evaluation, by sharing new tools for clinical evaluation of bedside behaviors of students – including the physical examination.

The posters will focus on preparing Educator Portfolios and on technology. Please e-mail me, if you will be bringing a poster on any of these

topics: szm1@Columbia.edu. The posters at the SIG are meant to be sharing of ideas and examples of good work – not necessarily of medical education research. So don't be shy – and volunteer to submit your ideas – especially if you are a new COMSEP member – as it's a great way to get started in contributing to the group.

Finally, we will update news from around the education globe and set the agenda for the next three years – when a new chair will take the reigns.

Be sure – that there will be fun, learning, comraderie – and food – as instituted and continued by past SIG chairs- Richard Sarkin and Helen Loeser.

**Alliance for Clinical Education (ACE)**
Submitted by Bruce Morgenstern

ACE, the Alliance for Clinical Education, is the organization of the core clerkship directors' organizations, including: the Clerkship Directors of Internal Medicine (CDIM), the Association of Directors of Medical Student Education in Psychiatry (ADMSEP), Consortium of Neurology Clerkship Directors (CNCD), Association of Professors of Gynecology and Obstetrics (APGO), Society of Teachers of Family Medicine (STFM), the Association for Surgical Education (ASE), and of course COMSEP. Over the short existence of ACE, two of COMSEP's representatives have been ACE President – O.J. Sahler and the current president, Fred McCurdy. ACE members have asked Fred to stay on as president even as he transitions to a new position as department chair in Amarillo.

In 2002, ACE published a paper on the impact of managed care (in the November issue of Academic Medicine), and submitted a paper of the expectations of and for clerkship directors that will appear in early 2003 in Teaching and Learning in Medicine (TLM). ACE continues to nurture its relationship with TLM, as evidenced by the recent call for reviewers from COMSEP. ACE is now developing a study to address the interaction of medical students and pharmaceutical corporations. Interested members from COMSEP may well be solicited soon.

ACE has also helped APGO in its efforts to create a competency-based interdisciplinary women's health curriculum. COMSEP members involved in this effort have included Nan Kaufman, Nick Jospe, and Cindy Christy. At the 2002 AAMC, ACE sponsored a session on interdisciplinary collaboration in undergraduate medical education. Fred McCurdy represented COMSEP.

ACE continues to work with the Group on Educational Affairs of the AAMC to strengthen its role as the primary group representing clinical undergraduate medical education.

**Faculty Development Task Force**
Submitted by Bill Wilson and Steve Miller

There is no "off-season," "post-season," or "pre-season" for the Faculty Development Task Force..... our members have been busy preparing workshops for the upcoming COMSEP meeting in Colorado and with activities related to the journal club. Plans for Bloomfield will include a "Meet the Experts" lunch on Friday as well as renewal and continuation of our previous mentoring activities. Announcements related to both of these programs will be sent out later by email and will be posted on the website. Steve Miller has been actively working with the editorial board of the journal club in preparation for the latest round of article reviews. A pre-

conference workshop for new clerkship directors will be held on Thursday, and a variety of workshops, including some of the "core" topics, are scheduled for Friday and Saturday. A workshop for "mid-career" clerkship directors, discussed at last year's meeting, is slated for Friday afternoon. We welcome all interested COMSEP attendees to come to our task force meetings (Friday morning and Sunday morning) to contribute your energy and ideas.

*As I have commented in years past, I can't thank Steve Miller enough for his hard work and organizational skills in coordinating the annual "Journal Review." This feature has become the highlight of the Pediatric Educator. On behalf of all COMSEP members and those non-members who read the Pediatric Educator, a heartfelt thanks to all of those who contributed to this year's "review." (G.F.)*

## Pediatric Educator: Journal Review

Welcome to our ninth 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.

This edition will have two areas of concentration and a number of single studies. The concentration areas are clinical reasoning, and professionalism and humanism. Both of these are complex behaviors, with similar challenges for teaching and evaluation.

This also marks the second 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. The questions are often "Yes or No" questions – so it should be easy. They will be posed at the end of each review.

Please, e-mail me at szm1@ Columbia.edu or through the COMSEP web site with your comments. (SM = Steve Miller)

**Pediatric Educator Journal Review: Vol. 5, No. 9, January 2003**

Bob Swantz, MD
Kent Stobart, MD
John Venglarcik, MD
Jamie Hoffman-Rosenfeld, MD
Linda Tewksbury, MD

**1. Assessing the Reliability and Validity of the Mini-Clinical Evaluation Exercise for Internal Medicine Residency Training. Durning, SJ, Cation, LJ, Markert, RJ, Pangaro, LN. *Academic Med* 2002; 77:900-904.**

**Reviewed by Sherilyn Smith, University of Washington.**

Purpose: This research study examines the validity of the mini-clinical evaluation exercise (mCEX) on PGY-1 internal medicine residents at one institution. The authors compare the mCEX to the American Board of Internal Medicine monthly evaluation form (MEF) and the American college of Physicians/American Society of Internal Medicine in training examination (ITE).

Methods: The scores of different sections of the mCEX, MEF and ITE from 3 groups of residents (n=23) were reviewed and compared. The sections of the mCEX during the study period were: clinical skills history, clinical skills physical examination, clinical judgement, humanistic attributes and overall clinical competence. The MEF contains sections on: clinical skills history, clinical skills physical examination, clinical judgment, humanistic attributes, medical knowledge, medical care and overall clinical competence.

Results: Each resident had an average of 7 mCEX, 12 MEF and 1 ITE performed during the study period. The mean scores on the mCEX and MEF were 7.5 (of a possible 9) and 7.67 (rating scale not stated). The authors found good correlation between the mCEX and MEF in clinical skills, clinical judgment, humanistic attributes and clinical competence (correlation coeffiencents ranging from 0.59-81). The mean scores on the mCEX did not change through out the study period.

Comments: The strengths of the study are the methods used to evaluate the validity and reliability of the mCEX. Additionally, the study compared tools commonly used to assess internal medicine residents' skills beyond medical knowledge. The good correlations are reassuring and indicate that we may be measuring the same skills with different tools. The limitations of the study stem from: the small study size (8 residents/year, mostly male residents and a single institution), lack of validation of the MEF as a sensitive evaluation tool, the large number of attending physicians completing the mCEX (46) and no description of faculty development for the use of the two clinical evaluation tools. The fact that the mean scores on the mCEX were relatively high (7.5 of 9) and did not change over time suggests that the power of the mCEX to finely discriminate levels of clinical skills is limited. Overall, the mCEX is probably a useful, time friendly method to evaluate feedback of clinical skills but needs continued refinement and study to maximize its utility. Pediatric educators should think about developing a similar tool or explore the application of the currently developed mCEX for residents and students.

**(Seems like we all wish we could find a tool that would encourage evaluation of real bedside practice by the students and promote more direct observation. Do you use a tool to collect evaluation data on individual patient encounters for your students? Do you think that such a tool would evaluate things that are currently not captured by traditional end of rotation global assessments – or by OSCE's and SP's? SM)**

**2. Levy B and Merchant T, Differences in Clinical Experiences Based on Gender of Third-Year Medical Students in a Required Family Medicine Preceptorship. *Academic Medicine* 2002;77:1241-46.**

**Reviewed by Bob Swantz, University of Rochester**

This paper addresses the question of whether the gender of a student or preceptor affects the student's level of experience with clinical skills during a three-week long third year community-based family medicine preceptor- ship. Over a 3 year span a total of 491 students rated 57 clinical skills on a 5-point scale (reflecting increasing involvement in and increasing frequency of activity during) by recall at the completion of their preceptorship experience. The clinical skills were categorized as "female-specific" (12 skills such as breast exam, contraception counseling, vaginal delivery), "male-specific" (3 skills of circumcision, testicular exam instruction, prostate exam), and "gender-neutral" (42 skills including EKG interpretation, flexible sigmoidoscopy, smoking cessation counseling, etc.).

Based on the gender of the student, there were differences in 13 of the 57 clinical skills (23%) with men having more experience than women in 2 of the 3 male-specific tasks and women having more experience than men in 8 of the 12 female-specific skills. Male preceptors provided more experience with 6 gender-neutral procedures, but no difference with regard to the 3 male-specific skills. Conversely, preceptors who were women provided more experience with 7 of 12 female-specific skills, and with management of depression and anxiety. The analysis of gender specific skills based on student-preceptor gender dyads showed that the highest levels of experience occurred with same-gender student-preceptor-patient combinations, while the lowest levels of experience occurred with same-gender student-preceptor seeing patients of opposite gender.

The implications for students and preceptors on a pediatric rotation largely relate to adolescent care, where clinical skills begin to assume gender-specificity. This could be a significant issue, since there often is a heightened sensitivity to/by the patient if they are undergoing a gender-specific exam/counseling, particularly if it is for the first time. Also, the disparities in experiences may have more of an impact on overall educational experiences, since students may not receive opportunities to learn many of these pediatric-specific skills in other rotations. The authors appropriately acknowledge the limitations of this study, including analysis of experiences in a single specialty, data collection by recall, and disproportionately fewer women preceptors. As well, the study was not designed to look at potential causal relationships of student preferences, preceptor practice characteristics, or patient preferences with any differences in experiences. These factors might in fact be more important than the gender issues. Although the results of this study are not unexpected, they are useful to increase student and teacher awareness of potential differences in learning experiences.

**(Outside of basic instructions regarding chaperones and privacy during the physical examination of near adolescent and adolescent patients - gender issues are rarely explicitly discussed in our clerkship - If you were precepting a male and female student – and an adolescent male was to be seen, would you be more likely to assign the male student to see the patient? Would you be more likely to have the female student see the patient if the patient were female? Try to answer as honestly as you can. SM).**

**The next two studies are part of a clinical reasoning theme.**

**3. Adapting the Key Features Examination for a Clinical Clerkship.**
**Hatala R and Norman G. *Medical Education* 2002;36:160-165**

**Reviewed by Leslie Fall, Dartmouth Medical School**

Description: The Key Features Written Examination is a component of the Medical Council of Canada's Examination that is aimed at assessing clinical decision-making skills. The test was designed to reduce the reliance on content knowledge that limits these forms of testing, where performance on one problem is a poor predictor of performance on a second problem. To do so, the "key feature" problem consists of a brief clinical stem followed by one or more questions requesting actions from the student. Content specificity is addressed by only testing the elements of a clinical problem, entitled the "key features," that are critical to its resolution. The test format and scoring system have been validated and an example question is included in the article's appendix. In this article, the authors describe the use of the Key Features Examination (KFE) question type in their Internal Medicine clerkship final examination at McMaster University. A question template ("blueprint") was developed and a total of 82 questions were written by faculty and residents, based upon the Clerkship Directors in Internal Medicine curriculum. Significant faculty input was required to generate a reproducible list of key features for each clinical problem (range 1-4). A dichotomous scoring system was developed. The 15-20 questions were administered to 101 students during a 2-hour test. Students' average score was 73.3% (range 44.0-90.0%). The authors compared students' performance on the KFE to other measures of student competence, including the encounter cards used to evaluate students' clinical performance during the clerkship, as well as their scores on the LLMC part I examination (equivalent to the USMLE exam). The authors found a poor correlation with the students' encounter cards (0.20-0.35) and a modest correlation with the LLMC medicine score (0.36-0.54). The authors conclude that these low correlations may indicate that the KFE is assessing the unique domains of clinical decision-making not addressed by the other evaluation tools.
Discussion: As someone who is interested in incorporating more clinical reasoning assessment into my clerkship, I was interested to read this study. I was encouraged to see that the Medical Council of Canada has validated the question type and is using it already in standardized testing. I found the example question more content-specific than I had expected and will contact the authors to better understand the question-type. I had also hoped that the authors would have compared the students' scores to a more global assessment of their reasoning abilities (i.e. attending or resident ward evaluation). I think this correlation might have been better, although I have my doubts about how well we assess this skill on the wards too. I was a bit discouraged, although not surprised, to see how much effort must be given to writing these questions well. It might be an interesting idea to develop and test a series of KFE questions based upon the COMSEP curriculum.
**(The annual meeting will have a lot of opportunities to share insights into teaching and assessing clinical reasoning skills – especially given our invited speaker – George Bordage. Do you have a standard *explicit* approach to teaching clinical reasoning – that is widely used by your faculty? If so – tell us about it. SM)**

**4. Comparison of an Aggregate Scoring Method with a Consensus Scoring Methods in a measure of Clinical Reasoning Capacity. Charlin B, Desaulniers M, Gagnon R, Bloin D and vander Vleuten C. Teaching and Learning in Medicine 2002; 14(3):150-156.**

**Reviewed by Leslie Fall, Dartmouth Medical School**

Description: This article describes another test of clinical reasoning assessment, the Script Concordance Test (SCT). The article focuses not on student performance, but on the method used to develop the scoring method for this test. In the SCT, students are given a brief clinical scenario and then asked a question in which they must rate the likelihood of a given hypothesis on a Likert scale of –3 (ruled out) to +3 (ruled in). An example question: "If you were considering the diagnosis of otitis media (hypothesis), and the mother told you that the child has been pulling on his ears (new clinical information), this hypothesis becomes: ruled out (-3) through ruled in (+3)." In this study, the experts were given the examination (60 items) and 2 methods of scoring the examination were developed. In the first, the aggregate method (A method), any answer given by the expert was considered correct and a weighted scoring system was developed. In the consensus method (C method), the experts were asked to reach a group consensus on which single answer was correct. The question asked by the study: "Do experts provide the same answer when they take the test individually and when they provide "the good answer" in a group meeting?" Fifty-nine percent (59%) of answers given by experts were different than those they gave when they were placed in the consensus condition! It is well known that experts differ in the multiple decisions that are made in a clinical reasoning process, whereas they usually converge toward a similar outcome. The authors argue that the aggregate scoring method better captures the kinds of judgments clinicians make in their daily reasoning process and that the expertise lies in subtle differences in reasoning processes, which disappear when experts are required to talk with each other to reach a consensus

I found both the description of the SCT and the results of the scoring study fascinating. More than the KFE described above, this test of clinical reasoning seems to me to better dissect and question how clinicians truly reason through a given clinical problem. The differences between the aggregate scoring and consensus scoring methods did not surprise me, and I agree with the authors that the aggregate method is significantly more in line with the task we are asking of students. However, I am not sure I agree with the decision to accept all of the experts' answers as correct (i.e. how would you answer the example question?). It seems to me that a range of acceptable answers would be a better method. I would suggest that anyone interested in clinical reasoning skills and in testing students' abilities in this area should read this article.

**(Do you formally assess diagnostic reasoning – in any way - other than by a global impression of the preceptors? SM)**

**Comment: The previous studies point out some important points about clinical reasoning. First, it appears that clinical reasoning is context specific – this means that someone might be a terrific "reasoner" for one type of problem - like abdominal pain – and poor for another – like the work up of vertigo. So, in order to teach or assess clinical reasoning – you need multiple cases to do so. Second, assessment tools (both of the methods described in the studies above) rely on recognizing the key features that lead to specific decisions and the weight each**

**feature has in swaying the decision. It is worth looking at both tools described to see the subtle differences. Which tool makes the most intuitive sense to you? SM**

**5. Steele DJ, Palensky JEJ, Lynch TG, Lacy NL, Duffy SW. Learning Preferences, computer attitudes, and student evaluation of computerized instruction.** ***Medical Education*** **2002;36:225-232**

**Reviewed by Bruce Morgenstern, Mayo Medical School and El Presidente de COMSEP**

(Commentary: Love it or hate it? Medical students' attitudes to computer-assisted learning. Vogel M, Wood DF. *Medical Education* 2002;36:214-215)

Summary: The article by Steele, et al is a mixed-methods design study that used validated survey tools and qualitative measures to assess the learning preferences and computer attitudes of 150 third-year medical students at the University of Nebraska College of Medicine between 1998 and 1999. The students, as a part of their surgical clerkship, had to complete a "prototype" computer-aided instruction (CAI) program on angiography. In addition to the survey tools, 31 students underwent qualitative interviews.

The Computer Attitudes Survey revealed that at the time, students were moderately positive toward computers in general, slightly negative about the role of computers in education, and generally positive toward the CAI angiography program. The students' scales that were determined from the Learning Preferences Inventory did not correlate with their attitudes toward computers.

Comments about the CAI program were interesting. There was a clear decrease in the attitude toward the program: 98% thought the presentation of the content was effective; 89.4% thought it was an effective way to learn; 78.8% preferred CAI to other forms of self-directed learning; 60.9% thought it was more effective than a lecture; 52.3% preferred CAI to reading texts; 43% preferred CAI to lectures.

The qualitative interviews revealed that the students generally praised the content, clarity, and organization of the program. The reported comments are positive and negative for all themes that were identified. For example, students were reported to like and dislike the flexibility of the CAI program (dislike in that it was not flexible enough). There was both preference and distaste in comparing CAI to texts and lectures. Students seemed to fear the loss of the student-teacher interaction.

The authors offer some helpful suggestions about developing CAI programs. They highlight the need for clear visual representations, simple navigation, with methods to let students know where they've been, self-quizzes and feedback, and some capacity for student notes and student-created summaries. The students need to be reassured that faculty interaction will not go away.

The accompanying commentary bemoans the problems with CAI studies to date: few studies, methodological flaws, lack of objective outcome criteria, and contamination between the intervention and control groups. Reported CAI initiatives often "fall short of their target user group's requirements." The commentary essentially points out that the glass can be viewed as either half full or half empty.

Morgenstern's opinion: I read the commentary first, and then the article, since that was the order in which I had printed off the on-line

issue of the journal. This was a mistake, in retrospect, as I was biased as I read the actual study. Several issues with the study, the most important of which was the years the students were surveyed, struck me. The surveys were from 1998-99. Even without the obvious last-century joke, in computer technology, that was nearly a decade ago. This was before widespread broadband, increasing wireless, and with fairly "old" software development tools. It would be interesting to see how, as children grow up digital, their attitudes towards computers and CAI change over time. I'd bet a more contemporary group of students would have felt differently.

I was also reminded of the concept of the "tyranny of the or," which I learned by using a Google search was used by Collins, J.C., & Porras, J. L. in 1997 in their book "Built to last: Successful habits of visionary companies." This concept is the superficially rational view that things must be either A or B, but not both. The ambivalence that the commentary noted from the study seemed largely based upon the students' fears that CAI would replace teacher student interaction. Why is CAI viewed as a teacher replacement (so we get A – teachers and students in some setting, or B – CAI, but not both)? I took an on-line course from the Socrates Distance Learning Group about teaching on-line courses last year. It was clear both from the materials we covered and the course structure that the teacher was critical, whether I could see and talk with him or not. *My fears are two-fold: 1) that there are many people who look at the money and think that CAI replacing teachers is the cheap solution, and 2) that there are course chairs who feel the need to add more content to their course all the time and will off-load some content to CAI, but simply add the knowledge to the students' load, by replacing the course time with something else.*

I also think that this article approaches several other interesting pedagogical concepts. They use the Learning Preferences Inventory (LPI), which yields a result that is based upon six scales of learning preference: abstract learning, concrete learning, individual learning, interpersonal learning, student-structured learning and teacher-structured learning. The authors do not address another important aspect of learner preference that is called cognitive style. The latter tells you the way in which a student can absorb new facts; some are visual learners, some are aural, etc. If you consider the 6 scales from the LPI and the factors in cognitive style, it's no wonder that no single teaching tool can ever clearly "win."

Finally, the authors might have been a bit more detailed about the angiography tool. There are differences between teaching and training, and it is not clear what the CAI tool was trying to accomplish. I think that the goal was to teach students something about angiography, and while they proved that some of it can be done via computer, it seems clear that teaching requires a teacher of some type. Training may not. To use a computer example, I have been trained to use Microsoft Word as a word processing tool. I have not learned Word. If someone had "taught" me Word, and helped me assure myself that I had in fact learned it, I would be able to deal with the capabilities of the software when I needed them (things like mail merges, auto-format, etc.). We hope to teach our students in way that equips them for on-going learning. In some way – real time or asynchronously – that requires a teacher. CAI will work when it is considered the adjunctive tool that it is, not a replacement.
**(Do you use CAI in your clerkship? If so, has it replaced the need for a "live" preceptor? Has it added more "material" to be "covered" in the same amount of time? SM)**

**6. Zakowski LJ, Seibert S, Van Eyck S, Skochelak S, Dodd S, and Albanese, M. Can specialists and generalists teach clinical skills to second-year medical students with equal effectiveness? Acad Med 77:1030-1033, 2002.**

**Reviewed by William G. Wilson, MD, Virginia (Guitar player – extraordinaire)**

Given the increasing emphasis on small group instruction in medical schools, course and clerkship directors frequently need to rely on a wide range of the clinical faculty to staff these sessions. In this study from the University of Wisconsin Medical School, generalists or specialists were randomly assigned to teach physical diagnosis to a small group of 2nd year medical students for each of two separate semesters. All group leaders were asked to attend an orientation session and were provided with a detailed outline of the objectives and activities of each session. Although the faculty groups in this study did include "general" pediatricians, pediatric specialists were not included. The teaching effectiveness was then determined by the performance of students on an OSCE at the end of the semester, by the students' evaluations of the preceptors as teachers, and by the self-evaluation of the preceptors. On two of the three measures (OSCE scores of the students and evaluations of the preceptors by students), there was no statistical difference between the teaching effectiveness of the specialists and that of the generalists. The only differences that reached statistical significance were in the self-assessment of the instructors; the specialists expressed less confidence in their teaching of the cardiovascular and pulmonary exams than did their generalist colleagues.

The students in both sets of groups did quite well on their OSCE, with mean scores of 93.8% (generalist groups) and 93.5% (specialist groups). This may indicate that the instruction was indeed comparable, but could also mean that the OSCE was not particularly rigorous. Nevertheless, this study does demonstrate the application of "outcomes-based" research in medical education. Perhaps an increased emphasis on faculty development among the specialists group leaders would help diminish their apparent lack of confidence in their ability to teach certain portions of the physical examination.

**(We have a running debate at our school as to whether students can learn general pediatrics if they primarily work on a specialty floor or office. Do you think students can learn general pediatrics if they spend most of their time with specialists and specialty patients? Do you assign students to specialists for the bulk of their outpatient training? Do you assign students to specialty inpatient services for the bulk of their inpatient experience? SM)**

**7. Quirk M., Stone S., Chuman A., Devaney-O'Neil S, Mazor K., Starr S., and Lasser D. Using Differences between Perceptions of Importance and Competence to Identify Teaching Needs of Primary Care Preceptors. *Teaching and Learning in Medicine*, 2002;14(3),157-163.**

**Reviewed by Lindsay Lane, Philadelphia Pa**

This study describes a novel method to tailor the offerings in a faculty development program to the needs of participants.

The authors' starting point is that faculty development needs assessments do not usually distinguish between content importance (how the preceptor rates the importance of the topic) and content performance (how well the faculty member perceives that they already perform the content) instead they focus only on one

dimension. This study looked at how, by taking into account both the "importance" and "performance" dimensions, the priority given to faculty development topics is changed.
The study population was 105 primary care preceptors in Family Medicine (n=59), Internal medicine (n=30) and Pediatrics (n=39) from 13 different medical schools. Surveys were sent that asked the preceptors to assess the importance of and their perceived competence in, 27 areas of clinical teaching grouped into three categories: environment of teaching, content of teaching, and general teaching skills. From the survey data the authors created a faculty development content "hierarchy". Topics that had a high importance rating and large discrepancy between importance and current preceptor performance made the "first tier", topics with mid -level importance but high discrepancy the "second tier" and topics with low importance and low discrepancy (however high the importance rating) made the "bottom tier".
The results indicate that a "2 dimensional" survey yields different priorities for topics than a "one dimensional" needs assessment. Although topics in the "content of teaching" domain were rated as very important they mainly fell into the bottom tier because they were already felt to be performed well. Of the six topics that were in the top tier using this method, five were in the general teaching skills domain. They were: 1.Understand how each learner learns best, 2. Use the most effective teaching behaviors to meet learner needs, 3. Talk to the learner about how well she or he has performed, 4. Choose teaching methods specifically based on what the student needs, 5. Assess what the learner needs to know, do, feel. One topic, falling second on the list, was in the environment of teaching domain: 1. Make time for teaching.

Comment: The distinction between importance and performance seems such a simple one to make but I guess I had not made it myself before reading this article! Because I regularly run faculty development programs for my clinical preceptors I've been wondering if my needs assessment, which only asks for a high/low rating of whether a topic should be included in the next faculty development session, includes the dimensions of performance and importance.

I feel better about having not explicitly addressed the "performance/importance" factor when I reflect that this article was published by the group from the University of Massachusetts which has been doing extensive, region wide community faculty development for a long time, and it's still taken *them* a while to figure this out!

The discussion at the end of this article mentions the problem of discrepancies between topics that clerkship directors may perceive as important but preceptors perceive as unimportant and vice-versa and the negative effect this may have on attendance at faculty development sessions. I'm sure we can all think of examples when we perceived a topic to be educationally important but the preceptors did not and we have had to do more than the usual faculty development to overcome this barrier. The reasons these authors suggest for discrepancies include preceptors not being aware of clerkship goals and not having access to the resources of the medical school. No surprises there and the solutions are obvious!
Just a quick FYI - There is going to be a 3 hour workshop at the APA meeting in May showcasing different faculty development programs from around the country. Many of you should find this of interest so make a note to "put it on your dance card"!
**(Using another method, What are your top 3 needs in faculty development – for you as a**

**clerkship director? SM)**

**Other studies of note from the editor's desk.**

**8. Bowen J and Irby D, Assessing the quality and costs of Education in the ambulatory setting. *Acad Med.* 2002;77:621-680**

This is an amazing comprehensive review of the literature. Issues that are addressed include:

a) Sites conducive to learning must include active patient care and participation by the students – an increase in passive observation is a warning sign of increasing faculty burden

**(Has the amount of passive observation been increasing for your students? SM)**

b) Excellent teachers are those who provide clear explanations, set expectations and provide feedback, show enthusiasm for the topic and the learner, and role model excellent care and communication. Most preceptors feel deficient in the setting expectations and providing feedback skills.

**(Do you provide faculty development for your ambulatory preceptors on giving effective feedback? SM)**

c) Little is known about the impact of education on patient care outcomes and on the utility of computer aided instruction – that is generalizable.

There is also extensive review of issues related to evaluation tools, impact on career choice and the cost of education – it costs 30% more to educate a student – either in time – or money.

**(Do you reimburse faculty who teach in ambulatory settings? If yes, how much? SM)**

And finally, some studies worth looking at for those interested in Professionalism and Humanism.

**9. William T. Branch, Jr. and Anuradha Paranjape. Feedback and Reflection: Teaching Methods for Clinical Settings *Acad Med* 2002 77: 1185-1188**

This is a terrific description of the components of giving effective feedback and facilitating reflection. Dr. Branch provides concrete advice on how to do both. He recommends that asking learners " what have you learned from this experience?" is an important step in facilitating reflection. The attributes of a compassionate and responsible physician include the ability to self correct – and reflection is a key skill.

**(Dr. Branch is famous for using written assignments to promote reflection among students and residents. Do you explicitly facilitate reflection among your learners? If yes, describe how. SM)**

**10. Hojat M et al, The Jefferson Scale of Physician Empathy, *Acad Med,* 77; S58**

This is an interesting study – it implies that empathy is a trait – that is somewhat stable across situations. However, most research (see Ginsburg S, et al – in the previous Journal review) suggests that empathy and professionalism are context specific – meaning – you might be more likely to behave with empathy in one situation – but not in another – depending on your level of comfort and knowledge of each situation. The scale does have implications – for measurements across groups. The authors imply that technology oriented MD's (surgeons – for example) don't need to be as empathetic. Would you agree? SM

**11. Eileen J. Klein, J. Craig Jackson, Lyn Kratz, Edgar K. Marcuse, Heather A. McPhillips, Richard P. Shugerman, Sandra Watkins, and F. Bruder Stapleton, Teaching Professionalism to Residents. *Acad Med* 2003 78: 26-34**

This is a terrific description of a 5- day retreat for interns – that focuses on teaching professionalism. It describes the components of professionalism and how they might be taught and assessed. This has some great ideas for both content and process of teaching.
**(Do you explicitly teach humanism or professionalism in your clerkship? If so – how? SM)**

*Finally, as has become my tradition, I like to conclude the newsletter with something humorous.*
Playwright Jim Sherman wrote this after Hu Jintao was named chief of the Communist Party in China.

**HU'S ON FIRST**
By James Sherman

(We take you now to the Oval Office.)

**George**: Condi! Nice to see you. What's happening?

**Condi**: Sir, I have the report here about the new leader of China

**George**: Great. Lay it on me.

**Condi**: Hu is the new leader of China.

**George**: That's what I want to know.

**Condi**: That's what I'm telling you.

**George**: That's what I'm asking you. Who is the new leader of China?

**Condi**: Yes.

**George**: I mean the fellow's name.

**Condi:** Hu.

**George**: The guy in China.

**Condi**: Hu.

**George**: The new leader of China.

**Condi**: Hu.

**George**: The Chinaman!

**Condi**: Hu is leading China.

**George**: Now whaddya' asking me for?

**Condi**: I'm telling you Hu is leading China.

**George**: Well, I'm asking you. Who is leading China?

**Condi**: That's the man's name.

**George**: That's who's name?

**Condi:** Yes.

**George**: Will you or will you not tell me the name of the new leader of China?

**Condi**: Yes, sir.

**George**: Yassir? Yassir Arafat is in China? I thought he was in the Middle East.

**Condi**: That's correct.

**George**: Then who is in China?

**Condi**: Yes, sir.

**George**: Yassir is in China?

**Condi**: No, sir.

**George**: Then who is?

**Condi**: Yes, sir.

**George**: Yassir?

**Condi**: No, sir.

**George**: Look, Condi. I need to know the name of the new leader of China. Get me the Secretary General of the U.N. on the phone.

**Condi:** Kofi?

**George**: No, thanks.

**Condi**: You want Kofi?

**George**: No.

**Condi:** You don't want Kofi.

**George**: No. But now that you mention it, I could use a glass of milk. And then get me the U.N.

**Condi**: Yes, sir.

**George**: Not Yassir! The guy at the U.N.

**Condi**: Kofi?

**George**: Milk! in China.

**George**: Will you stay out of China?!

**Condi**: Yes, sir.

**George**: And stay out of the Middle East! Just get me the guy at the U.N.

**Condi**: Kofi.
**George**: All right! With cream and two sugars. Now get on the phone.

(Condi picks up the phone.)

**Condi**: Rice, here.

**George**: Rice? Good idea. And a couple of egg rolls, too. Maybe we should send some to the guy in China. And the Middle East. Can you get Chinese food in the Middle East?

**REMEMBER**

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