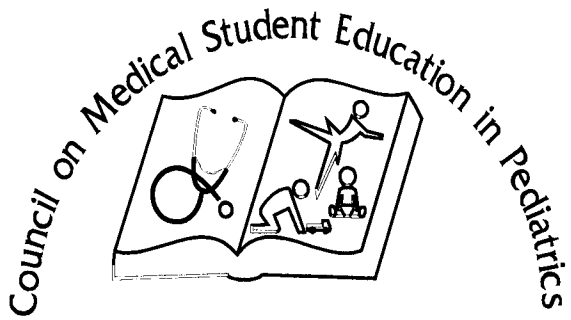
The Pediatric Educator



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Editor:
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President's Message
Steve Miller

It has been 4 months since we were all together in Florida – and I miss you all – a lot. COMSEP is special for the great work that gets done by the vibrant membership and for the great attachments and friendships we make with each other. (Kumbaya) I recently had the pleasure of spending a few days with my friends and colleagues, Steph Starr and Richard Sarkin at Mayo, and with Bill Raszka, Mike Giuliano, Lyuba Konapasek and Jenn Koestler in NYC and it rejuvenated my spirit.

I'm happy to say that COMSEP has been extremely busy and productive these past four months. We have committed ourselves to three things. These are:

- Making pediatric medical student education an outstanding experience for every student in the country – and thereby improving the care of children and families
- Creating new collaborations between those who teach students, resident, fellows and faculty.
- Inspiring and supporting the personal and professional growth of each and every member of COMSEP.

I'd like to ask that you make note of the following things that are going on to support these efforts.

1. We are designing a survey of COMSEP members, designed to define who we are, what we believe is critical to outstanding medical student education and most importantly, to define the value of COMSEP to promoting education and educators. I believe it is everyone's responsibility to fill out this survey carefully, if we are to meet our goals. For more details see Chris White's piece later on in the Educator.
2. The Curriculum and Evaluation Task Forces have been working to create a core competency document and begin to develop evaluation methods to match. This will be a unique contribution to the field of clinical teaching. It will be a crisp document that everyone can use. Bill Raszka, Lindsey Lane and Paula Algranati provide more details in this issue.
3. The Learning Technology Task Force has been working to revitalize our web site and create more dynamic dialogue among all of us. This will be a great opportunity for scholarship for our members as well. Mary Ottolini has written an update for us in this issue.
4. The Faculty Development Task Force has been working to solidify our mentoring program. They have also reached out to the

APA Faculty Development Special Interest Group for collaboration. Leslie Fall, Angela Sharkey and Shale Wong provide more details in this issue.

I have asked the new members to form a COMSEP Young Executive Group. Bill Wilson will be helping coordinate the new members by working with Aleca Clark.

Finally, the planning for the meeting in April 2005 has been exploding with creativity. There is no doubt that we will be better teachers after those fateful four days. We will be exploring ways to expand our imaginations and creativity to enhance our work with students. The sky is the limit on this. Mike Lawless describes this further in this issue.

So, I hope you enjoy this issue (including the Journal Review) as a way of touching base about our continued hard work. And so – everyone – hold hands and sing "Kumbaya."

ANNOUNCEMENTS/UPDATES

2005 Meeting Information

Mark your calendars - the 2005 COMSEP meeting will be held **April 7-10, 2005**, at the Grandover Resort and Conference Center in Greensboro, North Carolina. The Grandover, located in a beautiful wooded setting, is a grand European style hotel with state-of-the-art meeting facilities.

http://www.grandoverresort.com

Releasing the Imagination: Encountering the Arts in Education is the theme of our 2005 meeting. Imagination allows us to extend our borders and to be creative in our teaching, in our research and in our personal growth. Our ability to imagine the plight of others, to feel pain that we've not experienced, is at the center of empathy, of cultural sensitivity, and of social consciousness. The arts can be a powerful catalyst to release our imagination and that of our students.

Our keynote speaker will be Scott Noppe-Brandon, Executive Director of the Lincoln Center Institute for the Arts in Education in New York City. The Institute has a dual commitment to education and to the arts. It partners with teachers worldwide to enhance the education of learners of all ages and of diverse subjects. COMSEP's own Richard Sarkin, MD, State University of New York, Buffalo will also make a plenary presentation, *Using Fine Art to Improve Observational Skills.* The meeting will also feature the array of pre-conference workshops (topics to be announced in the near future), COMSEP workshops, research presentations and poster sessions that energize and educate meeting attendees year after year.

The Saturday evening social event will be at historic Old Salem in near-by Winston-Salem.

"http://www.oldsalem.com"

Old Salem is an authentic restoration and working museum of the colonial community that was settled in 1776. A reception and dinner will follow in the beautiful new Old SalemVisitor's Center.

Piedmont Triad International Airport (GSO), which services the Greensboro area offers non-stop daily flights from major cities on Delta, United, US Airways, Northwest and Continental. The Grandover Resort is just 16 miles from the airport.

Programs will be mailed in January. If you have any questions about registration, please contact Lisa Elliott at 919-942-1993 or via e-mail at lhe@abpeds.org.

The 2005 Meeting Hosts from Wake Forest University School of Medicine are: Michael Lawless, MD; Marcia Wofford, MD; and Dottye Currin, MPH.

The 2004 COMSEP Survey

Submitted by Chris White

Attention Clerkship Directors – the 2004 COMSEP Survey is coming! Why is this a big deal? Well, the last time we surveyed our membership (and the only time, for that matter) was in 1995. The results were reported by Larrie Greenberg, et al, in *Archives of Pediatrics & Adolescent Medicine* (1995;149:916-920). Much has changed since that time, so the COMSEP Executive Committee has tasked a committee (Chris White, Gary Freed, Larrie Greenberg, David Levine, Nan Kaufman, Renee Moore, Steve Miller, and Angela Sharkey) to create and administer a new survey. It will create a snapshot of who we are, what we do, and how we work to be the voice of pediatric student education on our campuses. The information obtained should be very helpful in creating a stronger identity and value for the role of pediatric clerkship director in academic medicine.

If the information from COMSEP members is to be helpful, however, it must be accurate. Thus the survey will be comprehensive (i.e. it will not be short!) and it is critical that all clerkship directors participate. We hope that it will take 30 minutes or less, and it will be Web-based to make it easier. Look for an e-mail message announcing the survey in the fall . . . . . ***We need your input!!!***

From The Academy

The AAP and Medical Students

Roxanne Shannon, AAP
Sections Coordinator
Division of Member Relations

In 1999 the American Academy of Pediatrics Resident Section established a membership category for medical students. Currently, over 500 medical students have joined as members and receive benefits such as free admission to the National Conference and Exhibition, *Pediatrics 101*, complimentary subscription to *Resident Report,* access to the medical student listserv and discounts on all AAP Publications and CME. At the request of pediatric clerkship directors the membership dues was recently reduced from $30 to $15 per year. With your help, we would like to try and double that number!! As pediatric clerkship directors you mentor medical students and serve as the AAP's initial and primary connection with them. Please make sure you have an adequate supply of medical student membership applications on hand. Your efforts to help link medical students to the AAP are much appreciated!

The AAP is also accepting applications for the Medical Student Outreach program that is being coordinated with the AAP chapters. Depending on the number of medical schools in your AAP chapter, either $300 or $600 is available to you to help resource collaborative projects between clerkship directors and chapters for medical student outreach. Projects can consist of anything from a networking opportunity to a gathering of pediatricians that can answer medical student questions. Funds for these projects are available on a first come first serve basis. Contact your local chapter to get involved.

The Academy has developed two resources for medical students: *Pediatrics 101* is a new pediatric career resource guide and the *Guide to Military Pediatric Residencies* promotes awareness of training opportunities available through the military.

If you would like to more information on any medical student program at the AAP, you can contact Roxanne Shannon at 800/433-9016 ext. 7864 or by email at rshannon@aap.org.

Starter Kit for Community Preceptors - A project of the Resident Education and Training (RET) SIG of the Section on Community Pediatrics American Academy of Pediatrics

With pediatric residents and students required to spend much of their time in ambulatory settings, the RET SIG, along with clerkship and program directors, wants to be certain these experiences meet curricular objectives. In addition, with our commitment to community pediatrics, the RET SIG hopes that by teaching and modeling the practice of community pediatrics, community preceptors will

have a positive impact on the attitudes of students and residents. The Starter Kit is therefore an introduction to community-based teaching. Its intended audience is practicing pediatricians with little or no experience in teaching. It treats "learners' generically as either students or residents. While there are differences in their needs as learners, the Starter Kit addresses teaching and adult learning issues in a basic way. The resources listed in the document further support teaching and learning in the office or clinic environment and differentiate the learning needs of students and residents.

The almost final draft of the Starter Kit is available at "www.aap.org/commpeds/resources/residents. html"

We welcome comments and suggestions from COMSEP members. We hope the Starter Kit will be the first step in building a library of web-based resources to help practicing pediatricians prepare the next generation of pediatricians for the challenges they will face in the community.

Revision of the APA Educational Guidelines

Submitted by Richard Sarkin

The revision of the Ambulatory Pediatric Association Education Guidelines for Residency Training in General Pediatrics is nearly completed. These revised Guidelines will soon be available online and provide a comprehensive, up-to-date curricular resource for pediatric residency programs including interpretations of the six ACGME competency domains. Users will be able to download preselected goals and objectives for standard and subspecialty rotations, as well as use a Build-Your-Own-Rotation function to adapt portions of the Guidelines to their own needs.

Several members of COMSEP have been very involved with this project.

Beta testing of the most recent draft of the Guidelines is nearly completed. It was anticipated that the final version of the Guidelines would be available in time for the 2004 PAS meeting in San Francisco. For the latest information on the APA Guidelines revisions, go to

"www.ambpeds.org/guidelines/index.cfm"

Pediatric Education Steering Committee

Submitted by Richard Sarkin

The Pediatric Education Steering Committee (PESC) has been charged with implementing the Future of Pediatric Education (FOPE) II Task Force recommendations

"www.aap.org/proofed/fope1.html"

Members of COMSEP have been working with the PESC to help implement the FOPE II recommendations that specifically deal with medical student education.

PESC functions under the auspices of the Federation of Pediatric Organizations (FOPO). Information about FOPO and PESC is available on the FOPO web site "www.fopo.org." The January, 2004 FOPO Newsletter is also available at the FOPO web site and summarizes the most recent PESC-sponsored activities including:

1. Conference on "Improving Patient Care, Safety, and Resident Education," Wilmington, DE, 10/13-14/04.
2. Forum on "How Training Programs Can Address the New American Board of Pediatrics Subspecialty Certification Requirements," Palo Alto, CA, 11/16-17/04.
3. Task Force on Women in Medicine

CLIPP UPDATE

Submitted by Norm Berman and Leslie Fall

Hello to all:
Just a brief update on the CLIPP project, as we recently sent an update to everyone on the listserv.

We are very excited to report that as of July 1 there were 15,000 completed CLIPP case sessions. This comes out to somewhere near 500 different users for each case. For this academic year there are about 40 schools that will be using the CLIPP cases as an important component of their clerkship. This broad usage was the most important goal of CLIPP, and the great support we have recieved from COMSEP in

developing CLIPP was absolutely essential. Sincere thanks again to all of you who have contributed so much time and effort to making this work to benefit of all the members of COMSEP, and more importantly to help all of our students.

The CLIPP Instructors' Area is now available to all clerkship directors - you can gain access by using the same Login and Password you use to access the CLIPP cases. The Instructors' Area is the place for all of the supporting materials and information you need to use CLIPP successfully in your clerkship. Check it out at : www.clippcases.org
and click the link to Instructors' Area.

The CLIPP working group is busily at work developing the final supporting material for CLIPP - the CLIPPnotes. And we will have a completed set of Final Exam Questions based on the content of the CLIPP cases by the time most of you end your first block of this year.

The other new thing coming from CLIPP is eCLIPPs - enhanced CLIPP cases. These will teach some of the more complex areas of pediatrics and medicine in general - Culture in Health, care of Children with Special Health Care Needs, and Genetics. These are in an early development stage now, but look for these to be ready for the beginning of the next academic year.

If you have any questions about using the CLIPP cases, please feel to contact either of us by email or by phone.

APA SIG Report

Submitted by Lindsey Lane

The APA Medical Student Education SIG was held on Tuesday, May 4th, the last day of the PAS meeting in San Francisco. Thirty people attended the SIG that focused on "Competencies in the Pediatric Clerkship." After an introduction by SIG co-leader Bill Raszka, SIG co-leader Lindsey Lane gave an overview of the challenges of instituting a competency-based assessment. The SIG attendees next worked in small groups to identify the "Top 10 Competencies" for a pediatric clerkship. A leader from each group presented a Top 10 list. The lists were collated and reorganized into topic areas and all attendees voted for the competencies they considered were in the top four. Jon Fliegel and Scott Jones beautifully orchestrated this process! The final part of the SIG was devoted to discussing the different scales available for assessing competency. Bill Raszka gave a short presentation and then more group work followed with presentations from group leaders about rating scales. Paula Algranati moderated the final element of the SIG where attendees practiced applying rating scales and discussed the pros and cons of using them in the clerkship.

All attendees enjoyed the refreshments that were sponsored by COMSEP.

ACE Update

Submitted by Bruce Morgenstern

ACE is the Alliance for Clinical Education. For those of you who do not recall, it is the organization of clerkship director organizations. COMSEP representatives now include Bruce Morgenstern, Cindy Christy, Mike Potts and Steven Z. Miller (How many know what the Z stands for?). The group holds regular conference calls, meets at the AAMC and responds to issues that affect clinical medical education. The major effort of ACE at the moment is the orchestration of a revision and republication of the Clerkship Directors' Guide. Although it will be called a "New" Clerkship Directors' Guide, all of us will find something useful in its contents. COMSEP members are well represented as both the lead authors on major chapters and potentially as contributors of sections within those chapters. Organization is still in process – if you volunteered, your name has been passed along to the editorial board and you may well be contacted in the next few months. The book should be completed by the end of 2004.

ACE has also been working on a Clinical Skills Task Force formed in collaboration with the AAMC. Progress on this has been slow, as one might imagine, given the enormity of the topic.

COPE Update

Submitted by Gary Freed

COPE, the Committee on Pediatric Education held its annual meeting July 25-26, 2004, in Chicago. The purpose of COPE is to "act as a think tank within the AAP for discussion, consensus building, and collaboration on emerging issues facing pediatric education."

Among the many interesting topics discussed over the two-day meeting, were several major issues that occupied a majority of the time. This included a comprehensive discussion on the Future of Pediatric Education II (FOPE II) recommendation that all residents have developed and implemented an individual continuous professional development (CPD) plan by the 3rd year of residency. The FOPE II CPD plan is not a curriculum, but rather a mechanism to assist graduating residents in preparing for the challenges of pediatric practice. The plan consists of six steps that serve as a general process for residents to develop an individualized, self-directed plan for life long learning. The six steps are intended to ensure adequate flexibility and foster individual creativity for the full spectrum of professional activities. Each of the six steps was presented and discussed. A suggestion was raised that this program should be introduced during the 1st year of residency and not to wait until the 3rd year. A small group of individuals agreed to "fine-tune" the draft that was presented to COPE and have the final product within the next 3 months.

Another major discussion developed during the presentation by the AAP Resident Section representative. The two topics triggering this discussion were requests for 1) a part-time residency policy and 2) a proposal to change the current fellowship application process. The Section on Residency (SOR) proposed that COPE and ultimately the ACGME and the pediatric RRC continue to work on the expansion of the availability of part-time residency positions. The most recent data indicate that 43 pediatric residents in the last 3 years have held part-time positions for at least part of their training. This accounts for 0.6% of pediatric residents nationwide. These residents come from 10% of all programs; 22 programs claim to offer part-time positions.

The other "hot topic" was the residency sections concern over the current fellowship application process. They report an increasing concern regarding the unorganized application process and multiple deadlines for subspecialty fellowship applications. Many deadlines are now in the early part of the 2nd year of residency. As most residents do not have a chance to participate in subspecialty training until the 2nd year of training, it is perceived as a real disadvantage to require residents to apply for fellowship in their 2nd year of residency. The SOR proposed that "the Council on Section review that application process and make recommendations to ACGME on a uniform application and application deadline approximately one year from the start of fellowship." No decision was reached during the COPE meeting whether or not to support this proposal.

I presented the COMSEP concerns over the new LCME requirements that I have reproduced below: "Each course or clerkship that requires interaction with real or simulated patients should specify the numbers and kinds of patients that students must see in order to achieve the objectives of the learning experience. It is not sufficient simply to supply the number of patients students will work up in the inpatient and outpatient setting. The school should specify, for those courses and clerk-ships, the major disease states/conditions that students are all expected to encounter. They should also specify the extent of student interaction with patients and the venue(s) in which the interactions will occur. A corollary requirement of this standard is that courses and clerkships will monitor and verify, by appropriate means, the number and variety of patient encounters in which students participate, so that adjustments can be made to ensure that all students have the desired clinical experiences. [Annotation revised and approved June 2004, effective immediately.]"

The participants at the COPE meeting were unanimous in their feelings that this requirement is "not possible" in Pediatrics. The suggestion from the participants was that COMSEP, as the clerkship

directors, should send a letter to the LCME voicing their concerns over this unreasonable mandate. A copy of this letter will be sent to AMSPDC to the FOP committee, and the AAP who will also write the LCME and support our position.

Finally, just for your information, Jerold Lucey, MD, the editor of Pediatrics reported that all journal submissions are now electronic. Since going to that format, they have received over 1,600 articles in the 1st six months of this year (they received approximately that number for the entire previous year). The "downside" to this is that only about 1 out of every 10 article submitted will be able to be accepted.

As a follow-up to the LCME discussion, and in response to a request by Steve Miller, Lindsey Lane and Paula Algranati prepared this excellent "White-Paper" in response to the LCME mandate of June 8, 2004.

The "New" LCME Standard
Two Steps Forward and One Step Backward

The Mandate

On June 8, 2004 the LCME approved revised accreditation standards for clinical education. Henceforth, clerkships (that require interaction with real or simulated patients) are required to:

1.Specify the numbers and kinds of patients that students must see in order to achieve the objectives of learning. *(It is not sufficient simply to supply the number of patients that students will work up in the inpatient and outpatient setting.)*

2. Specify the diseases states/conditions that students are all expected to encounter

3. Specify the extent of student interaction with patients and the venues in which the interactions will occur

4. Monitor and verify the number and variety of patient encounters *(so that adjustments can be made to ensure that all students have the desired clinical experiences.)*

Introduction

The recent announcement from the LCME, issuing new directives for "quantitative criteria" in clinical rotations generated lively discussions among COMSEP members on the listserv and among the executive committee during a conference call. Clerkship/clinical course directors from all the other major disciplines are similarly focused on clarifying the issues related to the announcement of this mandate. The purpose of this article is to provide COMSEP members with a perspective on this "hot topic," and also to stimulate further, ongoing dialogue.

The LCME mandate presents several important challenges. The core of the mandate is that clerkships must identify and quantify the required clinical encounters according to types of patients and conditions. Several assumptions are offered as starting points for this discussion. It is probably correct to assume that a universal goal of pediatric clerkship directors is to provide their students with rich clinical experiences through broad exposure to a diversity of patients and concerns. Conversely, it is probably also correct to assume that pediatric clerkship directors universally recognize that it is impossible to provide each student with exactly the same clinical experiences with respect to "disease states/conditions." The student in the January rotation is likely to encounter bronchiolitis, but is unlikely to see an enterovirus-related rash; conversely, the student in the July rotation is likely to see an enterovirus-related rash, but is unlikely to encounter bronchiolitis. Even for diseases that occur throughout the year (e.g., streptococcal pharyngitis) it is impossible to guarantee universal/equivalent exposure for every individual student. Given these realities, how can clerkship directors even begin to comply with this "core" aspect of the LCME requirements?

Many COMSEP members have suggested that computer simulated patient exercises could substitute for live patient encounters. There are a number of commercial products and other no-cost, grant-funded products (many of these are supplemented with high quality images and/or videos) that present a series of clinical cases that students work through in stepwise progression simulating actual clinical encounters. Mandating simulated patient encounters (to substitute for, and thus eliminate some of the barriers to uniformity of experience presented by live patient encounters) still leaves a fundamental question

unanswered. Which diseases states/ conditions must all students see on their pediatric clerkship?

Discussion

It is tempting to continue the discussion by pondering the answer to this fundamental question. Instead, it is more important to pause and recognize that the question is based upon the inherent assumption of the LCME mandate, that the focus of education should be the "process" or "content" of the clerkship. A better question to ask is "is this mandate educationally sound?" The LCME approach contrasts dramatically with the fundamental approach/questions that COMSEP and its' clerkship director constituency have been struggling with during the past two years. Originating from the ACGME mandate that targets "competencies" or "outcomes" as the central aspect of house officer training and evaluation, COMSEP members took a pro-active stance and agreed to adapt this competency-based focus into guidelines for medical student education and evaluation. COMSEP's leadership in this regard was subsequently validated when many other organizations and institutions initiated similar projects and related activities. The competency-based approach is the driving force behind the most important current project of COMSEP: a competency-based curriculum and evaluation document. The substantially revised COMSEP curriculum is scheduled for presentation in the near future and for review by the at-large membership. The final approved version will be disseminated throughout North America. A coordinated, new competency-based evaluation document with core competencies and instruments for evaluation is also nearing completion. These two endeavors move COMSEP two steps forward. The LCME mandate is a step backwards.

The wording of the LCME mandate is vague, as it does not provide any definition or clarification for "objectives of learning." At the same time, the LCME is specific with the expectation that we define the "content" of student experience. If we define or clarify the "objectives of learning" for the pediatric clerkship using competency-based language (i.e. define student outcomes), will we help students to achieve these competency-based objectives by defining, as the LCME now requires, the specific content of the experience? Evidence from the literature about competencies and acquisition of competency may help to answer this question. One of the core ACGME competencies is medical knowledge. The LCME requires that we identify the required disease states or conditions that students must encounter in order to achieve the objectives of learning. Is the assumption used by the LCME to justify the requirement valid? Does a clinical encounter with a patient who has a specific condition lead to an increase in medical knowledge about the condition? Or, conversely is acquiring adequate knowledge about a specific condition contingent upon encountering a patient with the condition? McCurdy et al demonstrated that medical students acquire adequate medical knowledge without having encountered the equivalent sampling of patients. Recent COMSEP listserv communications provide numerous examples of anecdotal evidence to support McCurdy's findings. A geographically diverse group of North American pediatric clerkship directors entered the discussion forum and enthusiastically shared their opinions, experiential evidence and several results of their home institution's data analyses. The "take-home" message from the members who participated was that medical students invariably acquire adequate medical knowledge despite having varied patient encounters (due to multiple factors including, different clerkship sites, different patient demographics, seasonal variations in timing of rotations etc.). Remarkably, there were no dissenting opinions from COMSEP members. Why are students able to acquire adequate medical knowledge? We believe that students listen and internalize what we tell them we want them to learn. Students also seem to know what we will test them on (we're pretty explicit about what will be on the test!). Our students have clearly learned how to succeed, irrespective of the specific patients they encounter. Because a multiple choice question (MCQ) test is a valid and reliable evaluation method to assess many aspects of medical knowledge, it would seem that we can conclude that the basic aspects of competency in medical knowledge are being achieved and will not benefit from the new LCME mandate.

There are other facets of medical knowledge that are

more complex and thus not adequately evaluated by MCQ examinations. Competency in medical knowledge also involves demonstrating that knowledge is appropriately applied when thinking critically or analytically. Medical knowledge competencies are also required for learning to do and being able to demonstrate more complex, higher-level tasks such as skills, maneuvers and procedures. Data from standardized patient (SP) tests have shown that a student's performance on one SP case does not predict performance on another case. It helps a student faced with a particular "problem" to perform well if they have seen that problem before. The LCME therefore may have a good case for saying that all students should see "core or common" diagnoses. However it may also be that some SP scenarios are too specific and deal with problems that the majority of students have not seen and that the SP "chief complaints" should be simpler and the ones that every student will have seen e.g. cough, fever, runny nose. etc. The literature on the acquisition of clinical reasoning skills/ problem solving skills supports the position that students do need to see multiple prototypical cases in order to develop "illness templates." Addressing this need seems to require a longitudinal or cross clerkship approach that would be best served by tracking student encounters throughout the clinical years, rather than within each clerkship. This is a very different mandate than the current LCME articulation, and altogether far more challenging in terms of overall competencies!

One of the challenges we face as educators is that students do not learn core skills from seeing patients who, on the face of it, should teach them! For example, despite auscultation of hundreds of hearts, students do not learn auscultation skills (Mangione et al); despite palpating numerous abdomens, students do not do the abdominal exam correctly; and despite seeing numerous patients with asthma, students do not learn how to give information about asthma management to patients (Lane et al unpublished data). The educational components that are missing include observation of students, assessment of their skills, and provision of substantive formative feedback. An LCME mandate that requires observation, assessment and feedback "X" number of times per clerkship would be powerful and beneficial compared to the current mandate! We are squandering the clinical learning opportunities available to students because teachers are not doing what teachers should do: assessing the level of competence, providing feedback, and directing subsequent learning opportunities. Students and faculty alike need to be provided with specific expected outcomes so that they have an opportunity to meet them, in the same way that a student who knows what is on the MCQ test learns the material without seeing patients with the diseases.

Conclusions

In conclusion, if we need to specify outcomes do we need to specify "patient types/venues?" Our guess is that if we specify outcomes then students will learn and faculty will adapt. If the LCME mandated observation and assessment of competence, the long-term benefit to medical education should be substantial, even in the current climate in which teaching faculty see fewer patients if they take the time to teach/observe students but are usually rewarded /judged on their ability to generate revenue. If national licensing bodies took a stand on student and resident outcomes and the role required of faculty to achieve the outcomes, then maybe we could begin to shift the pendulum back to a middle ground and make meaningful progress in the dialogue about balance between true excellence in medical education and efficiency in patient-care.

For now however, let's begin with the end in mind and define what a student should achieve rather than what type of patient they should see. It's important where a student ends up and far less important how they get there! Two steps forward for COMSEP; let's keep moving in the same direction.

TASK FORCE REPORTS

Evaluation Task Force (Summary of COMSEP Meetings)

Submitted by Lindsey Lane

The Evaluation Task Force met for two very lively and productive sessions during the 2004 annual meeting. The group discussed definitions of competencies and various evaluation methodologies. Task force members broke into four groups each with

the same charge: Develop a list of 10–12 core competencies that must be evaluated at the end of a six-week pediatric clerkship. Each group reported on the list developed and their choices were subsequently collated in a summary document. Not surprisingly, there was substantial consensus reached regarding the final list of core competencies. At the second session of the Task Force, members divided into two working groups with one group focused on fleshing out the history taking competency and the other group on the physical examination competency. Members agreed that the next steps post-meeting would be to continue further development of these two competencies and also to develop a list of appropriate evaluation instruments. The process for development of history taking and physical examination competencies and evaluation instruments will serve as pilots for development of the other competencies. Each working group developed a preliminary action plan with deadlines.

COMSEP Evaluation Task Force list of Core Competencies that must be evaluated at the end of a six-week clerkship:

1. Recognize a sick child
2. Obtain a pediatric history (including psycho-social/HEADS, nutrition, family history, from parent re child)
3. Perform a pediatric physical examination (including distinguishing normal versus abnormal)
4. Perform a developmental assessment using appropriate check lists
5. Deliver anticipatory guidance using appropriate check lists
6. Communication skills (including verbal presentations, written write-ups)
7. Clinical reasoning
8. Growth: Measurement and plotting
9. Fluids: Oral/IV
10. Child abuse: recognition, reporting
11. Immunizations: rationale
12. Medications/Pharmaceuticals: Pediatric differences

History-Taking Working Group: Action Plan

The history-taking group plans to develop a recommendation for history taking competencies that can/should be evaluated by May 1st and a toolbox of evaluation instruments/methodologies by June 1st. The history-taking group will circulate their working drafts to COMSEP members during the month of June and ask members to comment and add to the toolbox. Subsequently, the working group will finalize their recommendations for distribution to the membership.

Physical Examination Working Group: Action Plan

Evaluation Task Force: Action Plan

The task force will continue working throughout the year and with the goal of presenting a final list of competencies and toolbox, with consensus from COMSEP members by the time of our next Annual meeting in 2005.

Evaluation Task Force (ETF) Update

Submitted by Lindsey Lane

The current mission of the ETF is to be instrumental in enhancing evaluation of medical student performance during the pediatric clerkship in areas that are not amenable to MCQ examinations. The EFT's current project is to define core competencies that should be evaluated on a pediatric clerkship and then provide a "how to" manual or toolbox on evaluation. The task force attendees held a lengthy discussion at this year's COMSEP meeting about how to develop a practical approach to measure performance outcomes related to the ACGME competencies. The group decided that it is highly likely that UME will follow GME and use these same ACGME competency categories; thus the task force will also use these categories. Task force members then decided to work on creating a core list of competencies that cannot be assessed using MCQs by focusing on a list of "Top 10 competencies." Divided into four separate working groups, each group generated its own Top 10 list. The results from each group were collated into a summary document that was made available to the attendees of the COMSEP meeting. The top two items were history taking and physical examination. During the second ETF session, attendees worked on defining the pediatric-

specific competencies within the History taking and PE domains.

At the PAS meetings in San Francisco, ETF members who were in attendance, got together and further refined the list of competencies and also discussed realistic ways to evaluate each competency. During the APA medical student SIG a different group of pediatric educators replicated the task of defining the list of "Top 10 competencies." The results demonstrate remarkable congruence between the Top 10 lists generated by these two groups.

Since the PAS meetings, the ETF co-leaders have focused on the draft of the new COMSEP curriculum and extracted the competencies that ask students to "demonstrate" (i.e. those competencies that cannot be assessed with an MCQ test). These competencies are currently being collated with the competencies that were generated at the COMSEP and APA meetings into a document that will be distributed.

Summary:
A draft of the "Competencies" document will be available for review at the end of August 2004. The competencies that are included reflect the opinion of many (>100) pediatric educators from across North America and thus will have a high degree of face validity. We look forward to hearing your feedback and comments.

Faculty Development Task Force
Submitted by Bill Wilson

A total of 18 COMSEP members signed in, as well as two Learning Technology Task Force liaisons (Chris White and Kathy Previll). At the second task force meeting it was announced that Bill Wilson and Steve Wilson would be stepping down as Task Force co-leaders and that Leslie Fall would be assuming the leadership of the task force, with Shale Wong and Angela Sharkey serving as co-chairs. Bill and Steve were commended for their outstanding leadership of the task force.

Action Items: Leslie Fall will contact Shale Wong and Angela Sharkey to set up 4 conference calls for the next year. The goal of the phone calls will be to keep the work of the Task Force moving forward and to plan for the 2005 COMSEP meeting.

Review of Task Force's Activities for the 2004 Meeting *(Bill Wilson)*

We discussed the success of the pre-conference workshops: 1) the New Clerkship Directors (which had about 20 attendees) and 2) the Clerkship Director at Mid-Career (32 attendees). We discussed the progress of the Mentoring Program, including the pairing up of 8 new clerkship directors with COMSEP mentors and the "Lunch with the Experts." We reviewed the list of workshops at the current COMSEP meeting that arose as suggestions from the FDTF meeting last year.

Action Items: None

Mentoring Program *(Bill Wilson)*

The program was reviewed by Bill Wilson and the membership agreed that this was a valuable part of the FDTF that should be continued. Bill agreed to continue his oversight of the Mentoring Program as the past-FDTF leader (thank you, Bill!). After suggestions were made by the group, Bill agreed to a trial modification of the "Expert Lunch" to include specific tables with specific topics and pre-designated "experts" for a panel discussion on each.

Action Item: Bill Wilson, Anthony Acquavella and Michael Barone will develop the Expert Panel lunch, coordinated with the proposed Early Clerkship Director's Workshop agenda (see below)

Action Item: Bill Wilson will continue to oversee and organize the mentorship program for new clerkship directors.

FDTF Contributions to the COMSEP Web Site
(Bill Wilson and Kathy Previll)

The Task Force was asked by Robin Deterding and the COMSEP Executive Committee to provide material to the Web site that is relevant to faculty

development. We were joined in the second meeting by our LTTF liaisons as well. Possible material for the Web site was discussed and we agreed to start small and build over time. We agreed that material developed for the New Clerkship Directors workshop would be very useful for all COMSEP members, as would an annotated reference of "high impact" articles from the medical education literature. Ideas for future items for the website included a database of all COMSEP workshops and their leaders, and asking all future workshop leaders to provide us with an "on-line" product at the end of each workshop.

Action Item: Key material from previous New Clerkship Directors workshops from the past few years would be solicited from the workshop leaders by Leslie Fall.

Action Item: An annotated reference of "impact articles" would be developed by Renee Moore and Angela Sharkey.

Action Item: Leslie Fall will solicit Educator Portfolio material from the COMSEP membership.

Proposed Workshops for Next Year
(Bill Wilson and Leslie Fall)

The role of the COMSEP Faculty Development Task Force in overseeing the coordinated "roadmap" for the annual COMSEP workshops was discussed at length (see attached rough draft). Broad categories of workshops were discussed, as well as specific workshops that should be offered annually and semi-annually. We discussed the concept that there are really 4 "experience levels" at COMSEP and that some workshops/attention at the meeting should be directed at each group:

- New Clerkship Directors (first COMSEP meeting)
- Early Clerkship Directors (CD for 2-5 years)
- Mid-Career Clerkship Directors (CD for 6-10 years)
- Master Educators (CD for >10 years or Deans, etc)

We agreed that the New Clerkship Directors workshop should be offered annually and the present system of leadership for this workshop should continue (i.e. three workshop leaders with one new leader each year). In addition, the group felt strongly that an "Early Clerkship Directors" pre-conference workshop (aimed at clerkship directors that have been directors for 2-5 years) should be developed and should alternate with a Mid-Career Clerkship Directors pre-conference workshop. Additional COMSEP workshops that could arise from the membership of this Task Force were also brainstormed and volunteers were obtained.

Action Item: Leslie Fall will speak with Steve Miller and Mike Lawless regarding the role of the FDTF in calling for, planning and accepting workshops for the annual COMSEP meeting (akin to the Research Task Force involvement in planning and accepting the meeting abstracts and posters), based upon the "roadmap" being developed by the Task Force (see below).

Action Item: We will create a "Road Map" (template) of ongoing workshops for the annual COMSEP meeting. Based upon the lengthy discussion at the TF meeting, Leslie Fall, Shale Wong and Stephanie Starr will work over the next few months to develop the roadmap. In addition, Leslie will integrate all of the past COMSEP workshops into the list.

Action Item: Bill Wilson and Anthony Acquavella will work together to develop a proposal for an "Early Clerkship Directors" workshop (?pre-conference vs. standard workshop).

Action Item: Possible additional FDTF workshops to be submitted for the COMSEP 2005 Annual Meeting include the following. Leslie Fall will re-send this list to the volunteers during the "call for workshops" in October.

1) Pre-conference workshop on Clinical Skills Teaching and Assessment (Bill Wilson and Eugene Corbett)
2) Grading and grade inflation (Jose Gonzales and Michael Barone)
3) Regulatory agencies and their impact on clerkships (Steve Blatt)
4) Feedback (Angela Sharkey and Steve Miller)
5) Leadership Skills and Conflict Resolution

(Janet Fischel)
6) Multi-site clerkships (Shale Wong and Leslie Fall)
7) Educator Portfolio (Karen Marcdante.)
8) Mentoring of Faculty (Jose Gonzales)
9) Advising of medical students (Stephanie Starr)
10) Teaching pediatrics in specialty clinics (Charlie Peters and Steve Blatt)
11) How to be a good peer reviewer (no volunteers yet, but felt to be an important workshop)

Evidence-based Medical Education Reviews *(Steve Miller)*

Steve reviewed the EBME Journal Club activities for the last year. The group commended Steve for an excellent job and agreed that the journal club should remain a core activity for the FDTF. Steve expressed his desire to continue leading the journal club during his tenure as COMSEP president, but would also like a more junior member to help run the program with him. A sign-up sheet for journal and article reviewers was circulated. The deadline for the next reviews is June.

Action Item: Steve Miller will contact the EBME Journal Club Editorial Board and Reviewers in late May or early June regarding the next set of reviews.

Action Item: Steve will recruit a more junior COMSEP member to co-lead the Journal Club with him. Volunteers are being solicited at this time!

Brainstorm of Activities for Upcoming Year and COMSEP 2005 Meeting (All)

Over the course of the two task force meeting, the following additional activities were discussed and agreed upon. One item that was discussed at length was the concept of "career consultation and membership promotion." We felt that a more formal program would facilitate all of us doing more scholarly work, and be good for our CVs. The role of the FDTF in facilitating the development and implementation of a program of this type was briefly discussed at the final FDTF meeting, and was tabled for now. The types of programs that we discussed included:
--Career consult (junior or mid-career CD seeks career advice from a seasoned member)
--Scholarship consults (member proficient in grants and publications would mentor another member in writing a paper or grant)
--Site visits to your clerkship (mid-career or seasoned CD available to site visit programs with similar challenges, such as upcoming LCME review, multiple off-sites, etc)
--Speakers' Bureau (a formal list of COMSEP members and medical education talks; should we ask for a standard honorarium?)

Action Item: Leslie Fall will discuss the idea of the consultation services with the Executive Committee for their feedback prior to the FDTF moving forward with this.

Action Item: Renee Moore and Steve Miller are working with members of the Research Task Force to develop a general survey of the current COMSEP membership (an update to the survey that was done approximately 10 years ago).

Action Item: Steve Miller, Steve Blatt, and Karen Marcdante will develop an evaluation form for COMSEP workshops that will be specifically designed to measure the impact and outcomes (based on the CGEA website evaluation tool?).

Research and Scholarship Task Force

Submitted by
Cynthia Christy and Sherilyn Smith

We had a very busy and productive meeting in Panama City. The topics we covered were as follows:

A thematic analysis of the breakout sessions with the chairs will be done and distributed to members of COMSEP and their chairs via email. The task force devised a worksheet to capture the discussion of a work plan to promote and support scholarship within the clerkships. These sheets were distributed to all sessions and collected. Jan Hansen and Lynn

Manfred will pursue a qualitative analysis of the data sheets.

The task force then discussed three workshop ideas for the meeting next year. We would like to propose a pre-conference longer workshop on the basics of Qualitative Research to be presented by a leader in the field. The other two workshops proposed would be a shorter one on Qualitative Research and one on the topic of "How is what I do scholarship."

We discussed placement of the resources available to promote scholarship on the COMSEP website (i.e. journals, other meetings of interest, educational grants, faculty development programs, etc.). The task force will draft a document to be submitted to the website.

The subject of COMSEP awards for both individual advances in medical education and best clerkship was discussed and presented to the executive committee for further discussion.
The systematic review process was reviewed at a workshop put on by the task force. Ideas for future reviews were discussed. Our systematic review on the best way to teach communication skills was worked on and the next step is to finish entering information into our database and then plan for analysis and then writing of a manuscript. The task force communicates regularly via conference calls.

Learning Technology Task Force Report

Submitted by Mary Ottolini

Robin Deterding is turning over the leadership of the Learning Technology Task Force (LTTF) after years of outstanding leadership, especially in designing and maintaining a great resource: the COMSEP website. It will take three people to replace her: Chris White, David Levine and Mary Ottolini. The Web site is a great resource, but it is really underutilized. We are determined to make it a dynamic vehicle for sharing teaching resources, innovative curricula, evaluation tools, educational resource, and just discussing common interests and problems.

Although we are all very busy, keeping information current and relevant is crucial. Appointed liaisons to the other task forces will be responsible to gather new information about ongoing activities and for planning the annual meeting. Look for several new/updated sections under the "Scholarly Activities" tab. The Pediatric Educator will soon be available in PDF format. Reviewers for Steve Miller's Journal Club will enter and post their reviews here as well, so that reviews can be archived and easily retrieved as needed later. A previously unused section, the "Feature Article" will be a brief review of a topic, such as technical tips to enhance your clerkship, or of some resource or technique that you or your colleagues have developed that could be used to enhance pediatric medical student education. Feature article reviews can also be submitted on line. They will be reviewed and posted by members of the LTTF, so will count as a peer-reviewed electronic publication for your CV!

Pediatric Educator: Journal Review

Welcome to our twelfth 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. The ever-present Chris White will be helping with this. 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 asking people to review or comment on book articles and movies that they have found influential. This new section should be a lot of fun.

Pediatric Educator Journal Review : Vol. 6, No. 12, August 2004

The staff includes anyone who has participated in reviews over the past 3 years.

Chief Editor:
Steve Miller, MD (review all journals)

Editorial Board:
Janet Fischel, PhD (Acad Med and Medical Education and JAMA)
Karen Marcdante, MD (Advances and Med Education on Line and Acad Med and Lancet)
Lindsey Lane, MD (Medical Teacher and Teaching and Learning and Archives and J - APA)
Lynn Manfred, MD (NEJM and Teaching and Learning)
Bruce Z. Morgenstern (Teaching and Learning)
Larrie Greenberg, MD (Book Reviews and Classic Articles)

Reviewers:
Leslie Fall, MD
Randy Rockney, MD
Sherilyn Smith, MD
Jeff Longacre, MD (and USUHS members)
Maxine Clarke, MD
Bruce Morgenstern, MD
Bill Wilson, MD
Shale Wong, MD
Marcia Wofford, MD
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Jamie Hoffman - Rosenfeld, MD
Linda Tewksbury, MD
Angela Sharkey, MD
Karen Marcdante, MD
Kathleen Previll, MD
David Levine, MD
Linda Willies-Jacobo

1. Prideaux, D. Clarity of outcomes in medical education: do we know if it really makes a difference? [editorial] *Medical Education* 2004; 38: 580–581

Hays R and Baravilala W. Applying global standards across national boundaries: lessons learned from an Asia-Pacific example. *Medical Education* 2004; 38: 582–586

Talbot M, Monkey see, monkey do: a critique of the competency model in graduate medical education. *Medical Education* 2004; 38: 587–592

Rees CE. The problem with outcomes-based curricula in medical education: insights from educational theory. *Medical Education* 2004; 38: 593–598
Reviewer: Bruce Z Morgenstern

These four papers are a linked series on the tension between the regulatory-agency driven demand for measurable outcomes and the educators' goal to let process impact outcomes – something that underpins Problem-Based Learning, where the outcomes are intended to be subordinate to learner-defined goals.

The commentary by Prideaux sets the stage and offers the following eight questions to help guide the reader's progress through the other three papers. The questions, reproduced directly (i.e., plagiarized, but well ascribed to the author) here are very cogent as we wrestle with the recent LCME rule discussed on the COMSEP list:

"1) How do outcome statements drive student learning? 2) Is student learning driven more by statements of outcomes or statements of what is to be assessed? 3) Do different types of outcomes (standards, competencies, broad outcome statements) drive student learning in different ways? 4) Do locally, nationally or globally derived outcomes drive student learning in different ways? 5) Do outcome statements encourage or discourage student direction in learning? 6) How do outcome statements drive teacher activity, selection of content, selection of learning activities assessment? 7) Does the adoption of externally derived outcomes affect teacher and

student engagement with the curriculum? 8) Does participation in the process of determining outcome statements affect teacher and student engagement with the curriculum?"

Hays and Baravilala describe a site visit to the Fiji Medical School (I think that would have been a great experience) in which the World Federation of Medical Education (WFME) standards were applied. [The WFME standards can be found at "www.wfme.ku.dk/wfme"]

It became clear to the site visitors that international standards have their place, but they must be applied in a local context. The parallels to the LCME visits are clear: can the standards that apply to my alma mater (Jefferson, with a large class size and a geographically separate campus) be simply applied to my most recent home (Mayo 42 students on essentially a single campus)?

Talbot, in the best titled paper of the four (Monkey See, Monkey Do) takes on the competency movement with some challenges and the use of a slightly different educational paradigm. He describes the messianic fervor" of the competency movement, and points out that a "competency construct is a learning paradigm: it is not the same as competence, which is a step on the road to professional excellence....Most experts seem to recognize that competence is a matter of degree, whereas the planner views it as a binary yes/no model."

Two tables from his paper, explained using anesthesia training as the examples are presented to help demonstrate some of his points. Many of us are familiar with aspects of table one as learners progress from novice to expert. The second table describes the complexity of the demonstration of competence as opposed to discrete competencies.

Table 1 An overview of the expert practicum

Competency	Developing proficiency	Global development	Expertise
Knows how	Shows how	Does	Does well
Performance of discrete tasks		Critical engagement with the professional community's narrative focus	
Monocultural focus on discrete tasks	Monocultural focus on discrete skills	Development of questioning understanding, which underpins skills	Fully developed cultural knowledge
⇒	⇒ 'Performativity'	⇒	⇒

Table 2 The dimensions of competence (modified after Barnett[21])

	Academic competence	Operational competence	Life-world becoming
1 Epistemology	Knows that	Knows how	Reflective knowing
2 Situations	Defined by intellectual field	Defined pragmatically	Open definition
3 Focus	Propositions	Outcomes	Dialogue and argument as such
4 Transferability	Metacognition	Metaoperation	Metacritique
5 Learning	Propositional	Experiential	Metalearning
6 Communication	Disciplinary	Strategic	Dialogical
7 Evaluation	Truthfulness	Techno-positivist	Consensus in terms of professional maturation
8 Value orientation	Relative strength of discipline	Making the best of a 'quick fix'	The 'common good' (defined consensually)
9 Boundary conditions	Norms of intellectual field	Organisational norms	Practicalities of discourse
10 Critique	For better cognitive understanding	For better practical effectiveness	For better practical understanding

Finally, Rees comes back to the questions posed by Prideaux. She notes that regulations are driving the development of an outcomes-based education model in medical education. The need to delineate the outcomes has led to settings in which "curriculum designers and teachers control product-'orientated' curricula, leading to student disempowerment." In an interesting conundrum she points out that the strict listing of "learning outcomes cannot specify exactly what is to be achieved as a result of learning." She, as do Prideaux and Talbot, feels that medical educators must establish the "value of precise learning outcomes before blindly adopting an outcomes-based model."

These articles are an interesting read. They do not answer questions, but they do raise interesting issues as we rush headlong into outcomes-based education. Do all our courses need to be outcomes-based? Are we training skilled laborers or are we training critical thinkers who need to be able to synthesize basic knowledge with new material that life-long learning

skills and a certain fundamental skepticism foster? Will "competent" graduates advance the field as well as those who have some opportunity for learner-centered learning?

(Please read the accompanying piece by Lane and Algranati in this issue of the Educator [pgs 7-11]. *Do you believe the clerkship should have requirements for a set # of patient encounters or simulated encounters, for core disease entities? If yes, do you believe case series/seminars, could substitute for an encounter? Would a computerized case substitute for an encounter? Have you changed your curriculum since the ACGME competencies came out? What do you use more, ACGME competencies or AAMC MSPO Guidelines? Have you changed your evaluation approach as a result of the ACGME competencies project? Steve Miller)*

2. Ara Tekian and Laura Hruska, A Review of Medical School Records to Investigate the Effectiveness of Enrichment Programs for "At Risk" Students *Teaching and Learning in Medicine 2004. 16(1): 28-33.*
Reviewer: Randy Rockney

There has been an effort in place for at least the past 30 years to increase the number of underrepresented minorities (URMs) in US medical schools. In recognition of the fact that many URMs matriculate with educational deficiencies, a number of enrichment programs have been in place at many medical schools to either better prepare URMs and other "at risk" students prior to matriculation, or support them during medical school, or both. The authors of this paper note that the costs of these programs "are staggering," and ask the question, "how effective are they?"

The records of all "at-risk" students, both URM and non-URM, who matriculated at the University of Illinois at Chicago in 1992 and 1993 were evaluated. At-risk status was determined by averaging the student's three MCAT subset scores and total undergraduate GPA weighted by the competitiveness of the undergraduate school giving a score labeled the "cognitive index" or CI. The at-risk students, those with low CI scores, comprised 26.2% of the student population, 92 students, for those two years. A low CI was felt to suggest an increased likelihood of encountering academic difficulty during medical school. Instances of academic difficulty included the failure of one or more medical school courses or multiple attempts at passing either USMLE-1 or USMLE-2. The authors labeled these difficulties "delaying events" or DEs. The authors then compared the number of DEs to student graduation status labeled as no delay before graduation, delay before graduation, and withdrawal from medical school. They also compared the number of DEs to the type of enrichment programs, if any, in which the students participated either before and/or during medical school. Classification of student participation in enrichment programs included no program, involvement in "serious research," summer enrichment, summer enrichment and exposure to research, motivational activities, post-baccalaureate, post-baccalaureate and exposure to research. Research exposure in which students spent relatively short periods observing or assisting research was differentiated from serious research in which students were actively involved in the design, implementation, writing, and presenting of the research.

The study claims to test the hypothesis that the skills acquired during the enrichment program "will facilitate a medical education and be manifested at graduation." Students experiencing no DEs had significantly higher USMLE-1 scores. Students participating in serious research had the fewest DEs. The authors felt that conclusions about other types of enrichment programs had to be made cautiously because of small numbers of participants in each different program type.

COMMENTS

The opening of the Discussion section of this paper reads, "The results of this investigation may seem meager at first glance..." They follow that statement with an exhortation to medical schools to develop uncontaminated baseline measures of student ability that can be compared to measurable outcomes for enrichment programs. That such programs are necessary is evident from the difficulties encountered by students who matriculate at medical schools with

evidence of academic vulnerability, and a high percentage of those students are underrepresented minorities. These issues are well reviewed in the introduction to the paper. The authors conclude, "Medical education programs are rigorous and have high standards. Accountability for our enrichment programs should be equally rigorous."

(Interesting article and methodology. See the next review for comparison. SM)

3. A Review of Medical School Records to Investigate the Effectiveness of Enrichment Programs for "At Risk" Students. Tekian A, Hruska L.
***Teaching and Learning in Medicine* 2004; 16(1):28-33**
Reviewer: Linda Willies-Jacobo

Enrichment programs were designed to help those students with low GPAs and MCAT scores, since these measures tend to be good predictors of success in medical school. While there are numerous enrichment programs for underrepresented minority (URM) students enrolling into medical schools throughout the country, few studies have adequately addressed the effectiveness of these programs, in large part due to the low number of participants.

The authors of this paper set out to investigate the effects of participation in enrichment programs on student success during medical school using a general linear model procedure. The identified outcome measures of success for the purpose of this study were delaying events (DE), student status and the USLME-I scores. Delaying events were defined as: failure of a final course exam, failure of a course, and failure of an attempt at the USMLE-I exam. Three categories were established to describe student status: no delay (ND), delay (D), and withdrawal (W) from medical school. All URM and non-URM at-risk students (n=92) who matriculated to University of Illinois at Chicago College of Medicine (UIC-COM) in 1992 and 1993 had their records evaluated for undergraduate GPA, MCAT average scores, accumulated number of DE prior to the students' graduation, students' first attempt on USMLE-I scores, and participation in enrichment programs. Seven different enrichment program categories were defined (no program, serious research, other programs [summer enrichment, summer enrichment and research, motivational, post-baccalaureate, post-baccalaureate and research]).

There was a mean reduction in the number of DE among those students in research category enrichment programs, which was statistically significant ($p<.01$), with the serious research programs having the fewest number of delaying events. This finding was believed to occur because students in these programs tend to get more assistance with critical thinking and problem-solving skills than in other programs. The ND group was further noted to have a significantly higher USMLE-I score ($p< .001$), which was believed by the authors to be further evidence of success.

COMMENT
This was a provocative study that put forth an important question, especially in light of the high cost of enrichment programs. In all of its complexity, however, this article fails to provide us with significantly new information about the effectiveness of enrichment programs for underrepresented minority students. I agree with the authors that what may very well be needed are exit exams for better evaluation of program effectiveness. It does further lead us to wonder if we should be investing more heavily into those programs in which the emphasis is on critical thinking and problem solving.

(Should all students have required research as a means of enriching their approach to medicine? SM)

4. Coico, R, Kachur, E, Lima, V, and Lipper, S. Guidelines for preclerkship bioterrorism curricula (2004). *Academic Medicine,* 79, 366-375.
Reviewer: J.E.Fischel,PhD

Drs Coico, Kachur, Lima and Lipper set the context for this work in the shift over time in personnel deemed to be important to preparedness for health care responses to bioterrorism and biowarfare. Initially seen as a military health care responsibility, and then enlarged to include emergency medical personnel, the relevant personnel are now viewed as

broader based in health care trainees. The importance of curricula to address the critical knowledge, skills, and attitudes related to health concerns of bioterrorism is seen by the authors as essential to preclerkship medical training. The study uses an internet-based Delphi survey to question and prioritize topics of importance to preclinical curricula. The Delphi survey provides questions to a broad set of experts as a "reference group" and then summaries, provides consensus, and sends out "next round" of questions with feedback on the earlier responses; with multiple iterations, the authors note, one can gain consensus on multifaceted issues such as curriculum and evaluation strategies.

Why is this paper important to pediatric clerkship leaders? There are two reasons to read the report and contemplate its relevance; one is *process* and one is *content*. First, the article provides an exemplary model of a process for getting from step 1 to step 2 and onward in curriculum development, or in any other broad and complex scope of work in which consensus is probably a good thing to achieve. With little prior knowledge of the Delphi survey method, I headed to the internet and learned a great deal more. In the Coico et al. work, a study team set out to develop educational guidelines, albeit focused on preclinical teaching and learning. Next, experts in an array of pertinent fields (e.g., biowarfare, bioterrorism, public health, immunology, microbiology, the CDC) weighed in, converging on a consensus of what needs to be taught and how training should proceed. As a recheck and comparison, medical school microbiology and immunology chairs were queried, identifying topics given inadequate or inconsistent coverage, such as smallpox virus. Finally, the method of consensus development distilled learning objectives in six bioterrorism-related curriculum categories for preclinical teaching and learning.

The second, or content reason this paper is relevant, is found in reflecting back on our curriculum objectives or competencies for the clerkship in pediatrics. Are there implications for undergraduate pediatric education here? Some schools have already launched larger or smaller, targeted or longitudinal efforts in regard to training health care professionals to address bioterrorism/biowarfare, but the examples offered would suggest that many have not. Further, the authors of this research are sensitive to curriculum crowding and the need for restraint. However, they have also provided a stepping stone, by sketching curricular objectives, and by contemplating teaching and assessment strategies, allowing clinical clerkship leaders to consider building on the focused preclinical report. The work is informative, makes one think, and is relevant to COMSEP efforts in preparing physicians successfully for important and perhaps previously less well mapped roles in health care, relating well to anticipatory guidance, prevention, and disease containment models in pediatrics.

(Does your school have a specific curriculum on disaster preparedness? SM)

5. Review of a new AAP website: "www.aap.org/commpeds/additional/resident.html"

Reviewer: David Levine

AAP has a new section on the website, devoted to promoting community pediatrics to residents. It is mostly a repository of information and links including the following:

- AAP Policy Statements that embody the broad principles and practice of Community Pediatrics
- A PowerPoint Presentation to download and use to market to residents about considering choosing Community Pediatrics
- Links to the "Medical Home Training Program"

There is also a section on Department of Community Pediatrics Resident Related Initiatives – Programs that are engaged in projects as well as resources to engage in a project, including

- Resident related CATCH initiatives and information on how to apply
- Links to the Resident Education Special Interest Group at "www.aap.org/sections/compedsect/socpsigs.html"

- The AAP Resident Section at "www.aap.org/sections/resident"
- Anne E. Dyson Training Initiative in Community Pediatrics at "http://www.dysoninitiative.org"
- ACGME Program Requirements for Residency Education in Pediatrics at "www.acgme.org/req/320pr701.asp"

Overall, I think this is a nice start as a repository for resources for Community Pediatrics. There is nothing new on the site, but it is a worthwhile endeavor. Those that haven't looked at the Policy Statements or have resources about promoting Community Pediatrics may get some use from the site; otherwise this will be a useful repository to come back to.

(Does your clerkship include formal learning in the area of community pediatrics? SM)

6. Petrusa, Emil R., "Taking Standardized Patient-Based Examinations to the Next Level," *Teaching and Learning in Medicine*, 16(1), 98-110, 2004

Reviewer: David Levine

Dr. Petrusa is the Associate Dean for Curriculum Assessment at Duke University School of Medicine. The article reviews the literature and defines the current state of affairs with SP-based examinations, then discusses three important new areas that are being investigated.

The author begins by reviewing some of the literature on SP-based exams and supports the assertion that this modality is the most extensively researched educational innovation in the history of medical education. The article then defines three areas that need further investigation.

The first area of challenge and improvement suggested is "the gap between SP-based assessments and the current clinical curriculum of medical schools." The author documents that learners perform better on simulations that they have had practice in clinical encounters. There are a few solutions to the gap, including trying to make the exam fit the situation – using statistical analysis pass rates are set, checklists generated – but this may not assess the learning of the curriculum. The other is to make the clinical curriculum more appropriate to the cases being tested, a strategy recommended by the author.

The second area focuses on advances in these examinations that correspond to performance at advanced stages of professional development. For example, the subspecialist is able to find a diagnosis in their area of expertise with less information to confirm the diagnosis, but this may not be scored as well on a SP-based examination, since the learner would not document all the steps that the generalist would need to accomplish to make the diagnosis. This area, then, is ready for further development to define what are the expected thought processes and diagnostic reasoning appropriate at each level of medical education. One suggestion is to use nurse practitioners/ physician assistants, or residents as SPs in order to strengthen this role in the exam to help the learner develop diagnostic reasoning at the appropriate level. Clearly, checklists by SPs, written notes, and follow up questions are poor at evaluating the development of clinical reasoning.

The third area of exploration related to SP-based examinations is assessment of multi-person interactions in clinical encounters. More experienced clinicians can use SP-based exams to challenge themselves in cases that feature ambiguous signs and symptoms, challenging emotional states, socioeconomic and cultural differences. Really innovative work will be in the development of structured simulations that allow assessment of multiple persons in complex interactions, such as teamwork. Such simulations already developed include a simulated family where medical students interact with parents, children, and grandparents over a 16-week period. Another example is multidisciplinary scenarios where students from medicine, dentistry, public health, and allied health work on the coordinated care of patients. However, these modalities are used mostly for formative exercises. The challenge will be to define what are the expected roles and responsibilities in order to create a valid assessment tool for summative

examinations.

Overall, the article was well written, and at an "intermediate" or "advanced" level for the medical educator. This was a review article, so there was little to critically analyze and the arguments presented were well supported by literature in both medicine and in private industry. Having knowledge of each individual's SP program as well as an awareness of the NBME Clinical Skills Examination would be necessary to be able to fully understand the article. It does point out the three areas of concern and improvement that we have had in discussions at COMSEP and the APA meeting. I would recommend the article to those schools that have formative and summative SP exercises and examinations that are well established, to take their programs to the next level, and to study those advances.
(Do you use SP's as part of the third year pediatric clerkship? SM)

7. Ronald M. Epstein, Elaine F. Dannefer, Anne C. Nofziger, John T. Hansen, Stephen H. Schultz, Nicholas Jospe, Laura W. Connard, Sean C. Medrum, Lindsey C. Henson. Comprehensive Assessment of Professional Competence: The Rochester Experiment: Teaching and Learning in Medicine 16(2), 186-196.
Reviewer: Sherilyn Smith

This article provides an in depth description of a comprehensive evaluation of the clinical skills of 2nd year medical students. The authors provide an overview of the double helix curriculum at Rochester (which integrates early clinical experiences with basic science and then provides an opportunity for students to revisit the basic sciences later in their training). They then describe their comprehensive assessment of skills, knowledge and attitudes that occurs at the end of the 2nd year of training. This assessment uses multiple modalities including standardized patient exercises, multiple choices tests, structured evidence based medicine exercises, team work assessment and take home essays. Built into the exercise are evaluations from standardized patients, faculty preceptors and peers. The authors provide data on test question performance, distribution of student performance on each of the items and correlations between different tests in specific skills domains (such as communication skills and items of professionalism). The product of the assessment was an individual learning plan reflected areas that needed work (identified through the anonymous feedback & test results). The authors also provide students' evaluations of this exercise. Highlights in the article include the 19-item Rochester Communication rating scale developed to assess four domains of patient centered communication and the peer assessment form.

This article is worth reading to see how a comprehensive evaluation test could be constructed and how one might use different testing modalities to test skills. I particularly liked the two rating scales because these could be directly imported into clerkship training evaluations. A similar comprehensive test at the end of 3rd year/beginning of 4th year would be equally interesting. What was missing and would also be interesting is how these evaluations predict performance on other more traditional measures such as NMBE test scores and clerkship performance. This will most likely be presented in follow up papers.

(Do you use peer evaluations as part of your evaluation program in the third year? SM)

8. Erika N Ringdahl1, John E Delzell2 & Robin L Kruse. Evaluation of interns by senior residents and faculty: is there any difference? Medical Education 2004;Volume 38: 646 - June 2004
Reviewer: Sherilyn Smith

Background: Written evaluations of learner performance should give meaningful suggestions about clinical skills. However, encouraging evaluators to give meaningful written comments to trainees is difficult. Additionally, there may be differences between evaluations given by peers, residents, junior and senior faculty members.

Methods: Blinded retrospective analysis of 1341 written comments given to PGY-1 trainees by PGY-2 or PGY-3 residents, junior (< 6 years as a faculty member) and senior faculty members. Comments

were categorized into 12 groups, analyzed for positive/negative/neutral tone and effects of evaluator/learner gender.

Results: The authors had good agreement about categorization of comments and the method of analysis was sound. The majority of comments given were positive (81.9%). Junior faculty and residents were more likely to make "negative comments" than senior faculty (15.5%, 15.9% vs 9.8% respectively). There was no gender effect. Most comments were general and provided no specific feedback (generic "a great resident": 20.2%; resident attributes; "a great sense of humor" 18.0%, competence; "did a good job with a delivery" 14.1%). The remaining categories describing, knowledge, teamwork, decision making skills, patient interactions were infrequently used (<10% of the time). No information was provided about the areas for improvement or types of "negative comments".

Significance: This article illustrates how qualitative methods can be used to clarify important issues in medical education and inform future research projects. The similar findings apply to medical students (Carline et al Surgery 1986.). This type of information provides specific information that can inform faculty development and skills building sessions. It also provides a backdrop for future studies to assess the effectiveness of faculty/resident development in the area of giving feedback. The limitations of the study include a single institution and no description of the training the evaluators received regarding use of the evaluation instrument. Finally, I am not sure I agree with the assertion that senior faculty give less negative feedback than junior faculty/residents because they are "better evaluators." There was no specific data given about the negative comments and we didn't see examples of the feedback to gauge this for ourselves. Often, it is the resident who works closely with the student/intern who has insight into professional behaviors that are problematic.

(Do you think that the lack of "negative comments" in writing reflects lack of feedback in general or an unwillingness to put things that have been said in writing? Or – is it both – nothing said and nothing written? SM)

SPECIAL SECTION: PERSONAL CHOICES FOR LITERATURE OR FILM THAT HAS AFFECTED YOUR LIFE

1. Malcolm S. Knowles, Elwood F. Holton, Richard A. Swanson
The Adult Learner
Fifth Edition, 1998
Reviewer: Michael Giuliano

The Adult Learner has been described as the definitive classic in the adult educational literature. Knowles put the adult learner on the map and coined the term andragogy to distinguish learning by adults from children. This fifth edition stays true to the original 1973 version by reviewing the underlying roots of andragogy. Why do adults learn? How do adults learn? How can you best teach an adult learner? These are just a few of the questions addressed at the theoretical level in part one of the text. In addition, the text goes on, in parts two and three, to discuss advancements in adult learning and practical models of adult learning. Methods for developing effective adult learning programs are reviewed along with a self diagnostic tool to see how skilled you already are.

For anyone involved in the education of adults this is a must for your library on theory and a rich resource for practical ideas about process.

(Have you read Knowles' book? Have you read any books on the theoretical framework of education? If yes – which one(s)? Have you taught theoretical frameworks of adult education to other teachers (residents or attendings)? SM)

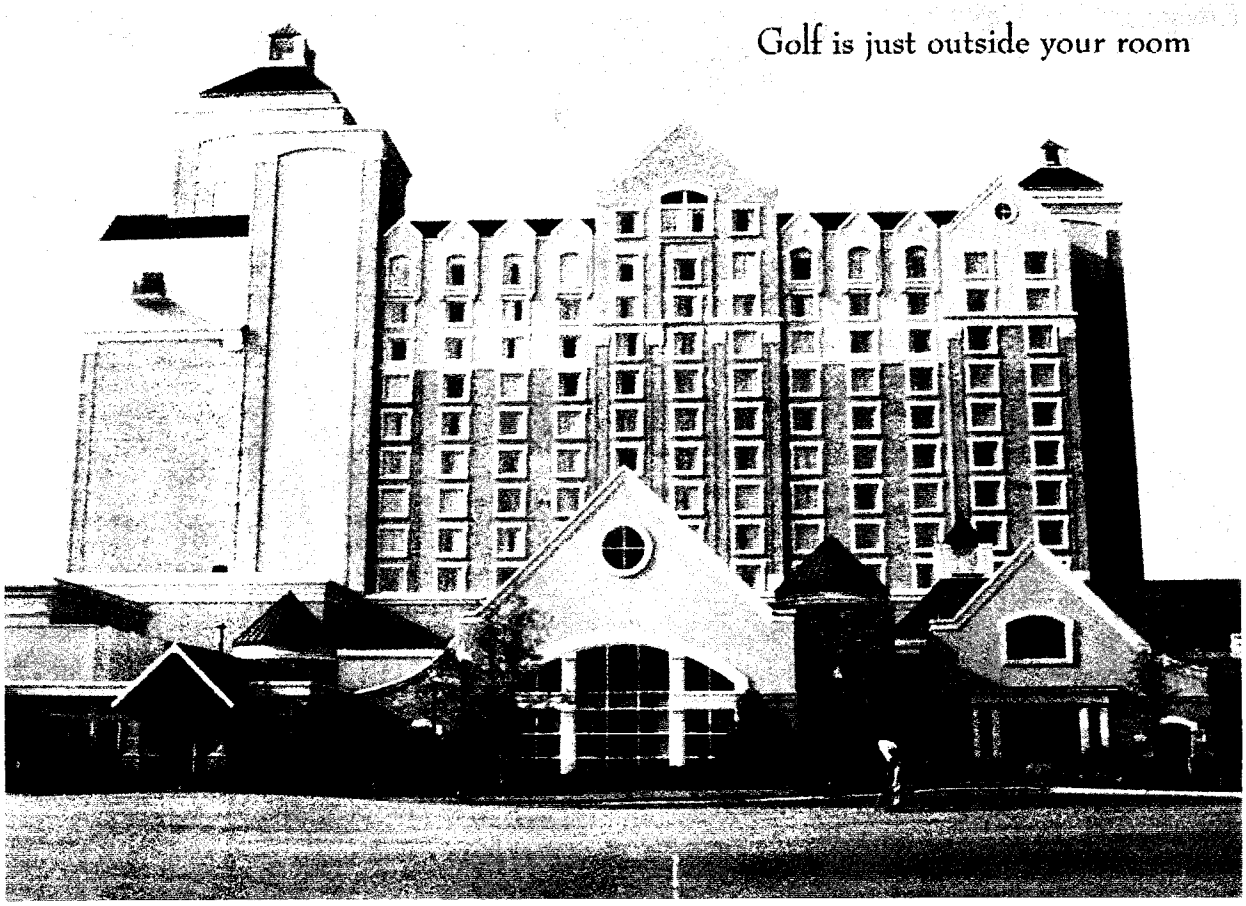
2. Personal Reflections on Teaching
Reviewer: Jimmy Stallworth

My favorite book on teaching is Tuesdays with Morrie. More personal to me is that one of my students got the book signed by the author and sent it to me. One of the most impacting films to me was The Killing Fields. I don't know if it was because I

did not go to Viet Nam and I knew of those who did or what. Perhaps it was just the timing of the film and my life views on war, etc. How one decides their favorites in life is sometimes a mystery if asked exactly why that particular entity "fits the bill." Such is my perspective regarding Tuesdays with Morrie, one of my most favorite reads. The book chronicles Mitch, the learner, and his visits with and flashbacks about, Morrie, his favorite college professor. Mitch learns very important life lessons as he visits Morrie on Tuesdays in the twilight of Morrie's life. "It's never too late" and "death ends life, not a relationship" are examples of aphorisms peppered throughout the book. The book can be read at one sitting and would not be considered a literary heavyweight. Yet its fundamental message, written with heart felt simplicity, scores a knockout. If the fire in your belly regarding teaching needs rekindled, read this book. As an academician in pediatrics, I only hope to have impacted on a learner in such an important way. Perhaps this book being one of my favorites is not a mystery after all.

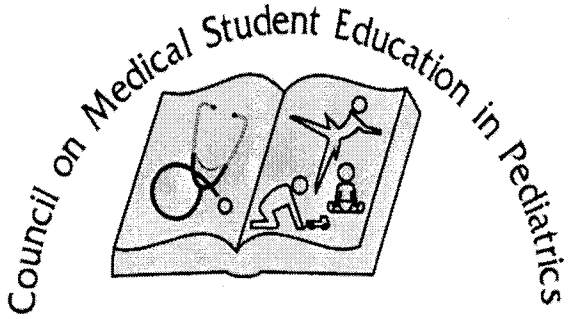
(Have you ever been as affected by a teacher as Mitch Albom – the author of Tuesday's with Morrie"? SM)

Don't Forget
April 7-10, 2005



See all y'all in Greensboro

The Pediatric Educator



Volume 11 Issue 1 **Winter 2004**

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

President's Column: January 2004

Bruce Morgenstern

Wow – another year has passed! I did OK with a few of my resolutions from last year, but as usual did not get them all right. I did avoid spending money on my computer (I figure that free software upgrades don't count), although I got a wireless card from the medical school here as part of a test of wireless tools. I was able to convince my wife that a wireless router at home would really improve my life, so I got that for the holidays, but that almost was 2004, and it was a gift, so maybe I was close to keeping my resolutions.

My resolutions for COMSEP may not have been quite as well kept. I thought I'd grade myself by reviewing last year's goals, which will help us, I hope, focus for 2004, and help Steve get off to a running start, when he takes over in March. Steve, by the way, this makes writing a column a lot easier.

Here's what I wrote in last January's educator, with my grades/comments in italics: 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. *This, I'm happy to say, we accomplished. You should have seen the results in many forums over the past 6 months. A-*

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. *We did not push this along as well as we'd have liked. The*

potential of the COMSEP site is still highly regarded by many who come across it, as the unsolicited comments I've received all year will attest, but the work remains to be done. D^+

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. *I did not pursue this actively, since the economy, especially with regard to giving, was somewhat slow to recover this year. I did make some plans and gain some experience asking for money. If Steve will let me, I'll keep working on this in 2004. C^+*

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. *The Curriculum and Evaluation Task Forces have been at work all year at this. They made the grade. A*

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. *So-so progress here, but some progress did continue. B*

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. *Give yourselves an A.*

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. *[I guess I blew that one.]* It would also be nice for the stock market to rebound, but somehow I doubt COMSEP will have much effect there, either. *[Oh for two, it appears].* 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 *[They all deserve an A^+!].*

So, with absolute confidence, I make no resolutions or predictions for 2004. Steve will write the next column, and he cannot quote me. I am really looking forward to seeing you in Florida. The meeting looks great, and I need the energy boost.

See you soon

Bruce

CLIPP Educator Update

Leslie Fall
Norm Berman
*CLIPP Co-director*s

With the help of many COMSEP members, the CLIPP project (phase 1) is essentially complete and CLIPP 2 has begun! The first goal of this second phase of CLIPP is to focus on developing, demonstrating, defining, and describing effective integration strategies for CLIPP. A CLIPP Working Group of 6 medical schools will be the main participants in this part of the project, but we absolutely do not want to exclude anyone else who is interested in working with this group. The second goal of CLIPP2 is to create 3 new learning modules covering the broad areas of genetics, chronic illness and cultural competency. These new modules will be a bit different than current CLIPP cases, and COMSEP authors for these new modules are currently being sought.

In addition to the new modules, the products of CLIPP 2 will include supplemental materials to help clerkship directors in putting CLIPP to use in their clerkships, and some additions to the CLIPP cases themselves that make the cases a better learning tool for students.

For students, the "CLIPPBoard" (the tool that allows a student to navigate back to earlier parts of a case) now includes the important clinical information of the case - the type of information that a student would jot down on a clipboard in an actual clinical setting. In addition, each case now ends with "Key Teaching Points" which summarize the clinical pearls in the case and all of the teaching that relates to the COMSEP curricular objectives covered by that case.

For clerkship directors, coming soon is the "Instructors Area" of the CLIPP website. These password protected pages will have information about the CLIPP cases that clerkship directors need to know about them, but which students should not know until after completing the case. For each case there will be a summary of the case, the key clinical findings, the differential diagnosis, final diagnosis, and learning objectives. The Key Teaching Points

and a set of final exam questions based on the teaching in the cases will also be available. Finally, a major development effort of CLIPP 2 is the "CLIPPnotes" which are materials that the clerkship director, other faculty, or students can use to further the teaching and learning around the content of each CLIPP case.

A lot has happened with CLIPP since many of you attended the CLIPP workshop at the last COMSEP meeting, so plan to come to the CLIPP workshop in Florida!

Alliance for Clinical Education *Submitted by Bruce Morgenstern*

The organization of clerkship directors' organizations, ACE continues to slowly establish its bona fides on a national level. As you can read elsewhere, ACE is participating with the AAMC in a Clinical Skills Task Force. ACE also has created the links to the journal Teaching and Learning in Medicine (TLM) that allows COMSEP to publish its abstracts. Through the TLM relationship, COMSEP may lay the groundwork for a specialty-specific education journal review, in which, for example, articles that relate to medical education and that have been published in "non-education" specialty journals are summarized for educators in other medical specialties who may not have seen the original publication. You may be hearing more about this from Steve Miller as the year progresses.

Several years ago, ACE was responsible for the development of the Clerkship Director's Guide, which was published by the AAMC. This guide will be updated in 2004, again under the leadership of ACE. As the contribution from COMSEP becomes clearer, you will be given the opportunity to volunteer to write some of the elements.

The president of ACE has been a COMSEP member more often than not. This year, after many years as ACE president, Fred McCurdy, a COMSEP member since day one will be passing the leadership on to Lou Pangaro, from CDIM. Fred has been instrumental in moving ACE over the past several years, and the momentum he imparted will carry us for years to come. Thanks, Fred!

Revision of the APA Educational Guidelines
Submitted by Richard Sarkin

The revision of the Ambulatory Pediatric Association Education Guidelines for Residency Training in General Pediatrics is nearly completed. These revised Guidelines will soon be available online and provide a comprehensive, up-to-date curricular resource for pediatric residency programs including interpretations of the six ACGME competency domains. Users will be able to download pre-selected goals and objectives for standard and subspecialty rotations, as well as use a Build-Your-Own-Rotation function to adapt portions of the Guidelines to their own needs. Diane Kittredge from Dartmouth is the Project Director. Several members of COMSEP have also been very involved with this project.

Pediatric Education Steering Committee
Submitted by Richard Sarkin

The Pediatric Education Steering Committee (PESC) 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 have been working with the 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). Information about FOPO and PESC is available at the FOPO web site www.fopo.org). The April, 2003 FOPO Newsletter (http://www.fopo.org/NEWSLETTER1.htm) includes a summary of ways for Pediatric Department Chairs to take leadership roles in implementing some of the FOPE II recommendations. For more information, also see Behrman RE. Commentary: Federation of pediatric organizations implementing the FOPE II recommendations. *J Peds* 2003;142:597-598.

A recent update regarding PESC
Submitted by guess who?
Richard Sarkin

I attended the Pediatric Education Steering Committee (PESC) meeting in Washington on 1/6/04. Here are a few items that I'd like to bring to your attention:

1) The American Board of Pediatrics is about to distribute their new "Training Requirements for Specialty Certification." This document will be available very soon through the ABP as well as on their website, www.abp.org. Enclosed is the most recent draft of FOPO's "Policy Statement on

Pediatric Fellowship Training."

2) A FOPO/PESC-sponsored subspecialty forum will be held in Palo Alto from 11/16-17/04 to discuss the ABP changes and requirements. Other topics will include a core curriculum for all subspecialists, mentoring, and teaching fellows to be teachers.

3) A FOPO/PESC-sponsored conference on redesigning pediatric resident education with an emphasis on practice-based learning will be held in Wilmington, Delaware, from 10-13-14/04. Teams of Chairs, high level administrators and pediatric program directors will be encouraged to attend.

4) A Task Force on Women in Pediatrics is being developed to identify the major issues of concern to women with suggestions for specific steps that could be taken to address the issues and implement changes when necessary. Specific issues that were identified include child care; part-time positions; faculty advancement (academic and administrative); gender differentials in salary and distribution of other resources related to academic careers (e.g. space, fellows, etc.); work accommodations for pregnancy and breast feeding; and special mentoring programs.

In an attempt to keep COMSEP members abreast of FOPO activities we have included in the Educator information from the latest FOPO Newsletter

Federation of Pediatric Organizations
Newsletter
No. 3, January 2004
Website: www.fopo.org

A Conference: Improving Patient Care, Safety, and Resident Education in Pediatrics will be held on October 13 to 14, 2004.

The Federation of Pediatric Organizations, with support from the Nemours Foundation, the American Board of Pediatrics, and the Department of Pediatrics of Jefferson Medical College, will convene a two day conference to bring together those leaders who want to initiate changes in clinic and inpatient services and resident training that will provide safer and better patient care for children as well as improved post-graduate pediatric education. The latter will particularly emphasize practice-based learning and improvement and systems based practice competencies. These leaders will include the Chair of the Department of Pediatrics, the Director of Pediatric Residency Training Program, and a Senior Hospital Administrator from each interested institution. Researchers relevent to evaluating proposed changes will also participate. The primary goals of the meeting are to develop a core set of principles and specific proposals for improvement that may be applicable to a variety of settings and to identify institutions who wish to collaborate in implementing and evaluating proposed changes.

The conference will be held at the Alfred I. DuPont Hospital for Children in Wilmington, Delaware, on October 13 and 14, 2004. Those who are interested in attending should reserve these dates on their schedules. Further details related to registration for the meeting will be available after March 15, 2004 at pedsref.org or by contacting Karen Bidus at kbidus@nemours.org (telephone number: 302-651-6752).

A Subsubspecialty Forum: How Training Programs Can Address the New ABP Subspecialty Certification Requirements will be held in Palo Alto on November 16 and 17, 2004.

The Federation of Pediatric Organizations, with support from the Lucile Packard Children's Hospital, the Department of Pediatrics of Stanford University, and the Lucile Packard Foundation for Children's Health, will sponsor a Subspecialty Forum that will focus on the specific ways in which pediatric subspecialty training programs might address the new American Board of Pediatrics requirements for subspecialty certification.

This meeting will be held at the Lucile Packard Children's Hospital and Stanford University in Palo Alto, California on November 16 and 17, 2004. Interested subspecialty program directors and department chairs should reserve these dates on their schedules. Additional information related to the meeting will be available after March 15, 2004 at http://www.lpfch.org/subspecialists forum/ or by contacting Susan Cooper at susan.cooper@lpfch.org (telephone number: 650-498-7633).

Task Force on Women in Pediatrics

The Federation of Pediatric Organizations has established a Task Force on Women in Pediatrics. The Task Force members are Drs. A. Arvin, R. Behrman, C. Berkowitz, P. Dickson, G. Freed, D.

Jones, L. Laskey, and B. Stanton and Mr. L. McAndrews. The group will be addressing the following issues:

1. What are the perceived issues related to Women in Pediatrics and is there data that would enable us to estimate the magnitude of these issues. For example, what are the gender-based differentials relating to:
   a. pediatric residency
   b. pediatric subspecialty training
   c. pediatric research careers
   d. academic promotion
   e. advanced administrative careers
   f. private practice of pediatrics
   g. public health careers

2. If there are real gender-based differences, what is their significance and importance to the future of pediatrics?

3. What are the causes for the differences and what can or should be done to address these matters?

4. What are the unique gender-based needs that should be addressed? What are the priorities? What steps should be taken to address these needs?

5. What are the non-gender based needs that should be addressed to make pediatric careers more family friendly? What are the priorities? What steps should be taken to address the needs?

Child Care: An Example of a Successful Self-Sufficient Infant and Child Care Program at Presbyterian Hospital and the Morgan Stanley Childrens Hospital in New York City

This program organized as a separate not for profit corporation provides services for hospital employees, including residents, nurses, and faculty. Those interested in obtaining more information about the program, please contact Dr. Behrman at rbehrman@fopo.org. Other successful programs are in operation at Johns Hopkins Hospital and DuPont Hospital for Children. We would also appreciate being informed about other experiences with medical center child-are programs.

St. Geme Awardee

Dr. Myron Genel was designated the 2004 St. Geme awardee by the members of the Federation of Pediatric Organizations.

Skills Task Force

Submitted by Sandra Sanguino

Many individuals in medical education have been concerned about the clinical skills instruction of medical students. The AAMC has talked about such problems as the lack of observation of students by faculty and the inability of faculty to agree on a standard of competency in clinical examination skills. COMSEP is currently participating in a project with the AAMC and the Alliance for Clinical Education (ACE). Under the direction of Gene Corbett, a recent scholar at the AAMC, the major clerkship organizations are working together to examine clinical skills education. The purpose of this taskforce is to bring together organizations that are concerned about clerkship education and to develop a proposal for a clinical skills curriculum in undergraduate medical education. The ultimate goal is to try to develop a consensus on the clinical skills that students need to acquire by graduation. As part of this process, Dr. Corbett compiled an extensive list of clinical skills that students were expected to attain in clerkships. This was based on a number of medical schools' curricula. It was quite surprising to see skills such as central venous catheter placement and cricothyroid membrane puncture. The task force is currently in the process of trying to develop a consensus on the general levels of skills education. This should assist us in trying to organize the list of specific skills in a way that carries a developmental message. I think this is an extremely important project and look forward to getting your input as this project progresses.

Research and Scholarship Task Force

Submitted by Cynthia Christy

The COMSEP research and scholarship task force has been quite active this year. We are doing a systematic review of methods to teach communication skills to medical students. The process will be described at a COMSEP workshop and an abstract has been submitted to the PAS meetings. Right now we're in the process of gathering and reviewing abstracts for the March meeting.

EVALUATION TASK FORCE REPORT

Over the last 12 months since the 2003 meeting the evaluation task force has focused on a project to define and develop pediatric competencies in undergraduate medical education. This is to be a

joint project with the curriculum task force. It is also a complex and difficult project that, as this report will show, is fraught with pedagogical and practical difficulties!

We initiated the process by sending the COMSEP members who attended the curriculum and evaluation task force meetings in 2003 the following e mail:

TO: Working groups from the COMSEP Evaluation and Curriculum Task Forces

FROM: Lindsey Lane, Paula Algranati, Bill Raszka

RE: Competencies and Evaluation for COMSEP Curriculum

Introduction: At our annual meeting, we decided that the Evaluation and Curriculum Task Forces would work together in small groups, to identify core and mastery level competencies and evaluation strategies for the COMSEP Curriculum. The members predicted that this project would take approximately 3 years to complete (addressing 1/3 of the topics/year). Now that fall is here, we're back on task. We reviewed the topics identified for work during year 1 and have taken the editorial liberty of deleting 1 huge topic (common acute illnesses) so as to make the load more manageable.

Working groups and assigned topics:

Topic	Please type your name next to 3 topics you would like to work on and label them 1st, 2nd, or 3rd choice	Check here if you volunteer to be the group leader
Development		
Anticipatory Guidance		
Skills (Hx, PE, Communication)		
Genetics and Dysmorphology		
Chronic Illness and Disability		
Child Abuse		
Emergencies		

Once identified, group leaders will initiate work with their group to accomplish the following by February 1: Determine the core competencies for medical students in your topic area.

a. Review the learning objectives AND competencies listed in the COMSEP curriculum under your topic.

b. Review the learning objectives AND competencies listed in the COMSEP curriculum under other topics that relate to your topic and should be considered by your group as well (eg, Anticipatory guidance has relevant materials found also in Prevention and Nutrition in the COMSEP column.

c. Write a series of core competencies for your topic USING MATERIALS from ANY part of "a." and "b." cited just above. IN OTHER WORDS, there are areas of overlap between what are called "learning objectives" and what are called "competencies" in the COMSEP curriculum in addition to areas of overlap in topics and you should not limit yourselves to thinking just about what is currently listed for your topics competencies (ie, under "learning objectives for the Skills topic it says, "identify the primary concerns of the patient and family" and, "avoid overuse of medical jargon"... Even though these are listed under learning objectives rather than competencies, you may want to incorporate some of these into your core competencies). Your topics' core competencies should be: what we expect each medical student to achieve (either they will or will not demonstrate achievement of each of these).

d. Write a series of "additional competencies that demonstrate achievement beyond the core level" (this is what we surmise the group meant by "mastery" competencies). The same directions apply to these additional competencies as for core competencies (see "c" just above). And, for these competencies also, the students will or will not demonstrate that they have achieves each of these.

e. Because medical schools are/will shortly

adopt the ACGME core competency areas for medical student graduation requirements, we want each group to determine which of the 6 ACGME core competencies each of your competencies fits into (e.g., Patient

Care,Medical Knowledge, Practice-Based Learning, Interpersonal/CommunicationSkills, Professionalism, Systems-Based Practice).

f. Identify for each competency (core or additional) what specific criteria demonstrate that the student HAS or HAS NOT done it. (What specifically, in behavioral/observable or testable terms is required to establish competency?)

g. Identify what evaluation tools/resources could/should be used to determine/ evaluate achievement of "f"

We received five replies to this e-mail.

In the meantime dialogue began amongst the COMSEP executive committee members about what other core clerkships were doing on a national level to develop competencies. The executive committee agreed that we should explore this and also get more information about the AAMC Task Force on the Clinical Skills Education of Medical Students, chaired by Dr. Gene Corbett. We reviewed the "Women's Health Care Competencies: Sample learning Objectives for Undergraduate Medical Education" created by APGO and Sandy Sanguino, the COMSEP representative to the AAMC Task Force, circulated that group's latest report.

A working group from COMSEP was identified to participate in a conference call to discuss these documents and the philosophy that COMSEP should take in defining competencies within our curriculum. They were: Paula Algranati, Roger Berkow, Lindsey Lane, Karen Marcdante, Steve Miller, Bill Raszka, Sandy Sanguino and Ben Siegel.

A conference call with Steve Miller, Sandy Sanguino, Paula Algranati and Lindsey Lane participating produced the following preliminary consensus:

- We should involve all the task forces in this project (curriculum, evaluation, faculty development and technology)
- Competencies for every section of the COMSEP curriculum are not necessary because we will produce a document that is too long and completely impractical.
- Indication as to which of the 6 ACGME competencies *our* competencies fall into will be given.
- The focus will be on core competencies that are pediatric specific (i.e. cannot/will not be achieved in other rotations)
- The competency document will be a practical "appendix" to the curriculum.
- This appendix will be a complete package that will allow a clerkship director to "teach and test" the competencies we select.

The next task is to come to a consensus about the core competencies that will be included. This will be a challenge because, as has become clear from review of other competency documents, the tendency is to have a wide scope rather than a distillation. Once the core competencies have been "distilled" from the curriculum work will begin on creating the appendix.

The individuals who volunteered to work on the project have been contacted and asked to develop a list of "top ten" pediatric competencies. This list will be circulated for review and comment to the other task force leaders and the COMSEP working group.

Once again, Steve Miller and his crew of editors and reviewers have done an outstanding job in preparing the literature review. My thanks to all of you who have contributed in making the Pediatric Educator Journal Review the highlight of the newsletter.

Pediatric Educator: Journal Review

Welcome to our eleventh 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 listserve 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.

Pediatric Educator Journal Review : Vol. 6, No. 11, January, 2004

The staff includes anyone who has participated in reviews over the past 4 years. This issue was primarily edited by Steve Miller and Janet Fischel.

1) Chief Editor: Steve Miller, MD (review all journals)
2) Editorial Board: Janet Fischel, PhD (Acad Med and Medical Education and JAMA)
3) Karen Marcdante, MD (Advances and Med Education on Line and Acad Med and Lancet)
4) Lindsey Lane, MD (Medical Teacher and Teaching and Learning and Archives and J - APA)
5) Lynn Manfred, MD (NEJM and Teaching and Learning)
6) Bruce Z. Morgenstern (Teaching and Learning)
7) Larrie Greenberg, MD (Book Reviews and Classic Articles)

Reviewers Include:

Leslie Fall, MD

Randy Rockney, MD

Sherilyn Smith, MD

Jeff Longacre, MD (and USUHS members)

Maxine Clarke, MD

Bruce Morgenstern, MD

Bill Wilson, MD

Shale Wong, MD

Marcia Wofford, MD

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Linda Tewksbury, MD

Angela Sharkey, MD

Karen Marcdante, MD

Kathleen Previll, MD

Barry Evans

Jon Fliegel

Mike Barone

Su - Ting Li

1. Effectiveness of the One-Minute Preceptor Model for Diagnosing the Patient and the Learner: Proof of Concept

Eva Aagaard, MD, Arianne Teherani, PhD and David M. Irby, PhD

Academic Medicine (2004) 79: 42-49.

Reviewer: Barry Evans, MD

Aagaard et al from the San Francisco Medical School provide some needed insight into two of the more common teaching methods used for students in their ambulatory rotations - the "traditional" and the "One Minute Preceptor Model (OMP)". The major hypothesis being that the OMP model, a model more in line with modern day adult teaching principals would prove to be the better modality.

The two models were used in two tightly scripted cases to create four videotapes wherein the same preceptor, student, and standardized patient performed the encounters. 116 faculty members from multiple faculty development programs were asked to rate the student's skills in history taking/physical examination, presentation, clinical reasoning, and fund of knowledge; to rate their own confidence in rating these items; and to finally rate the quality of the interaction. The participants were also asked to identify the two most likely diagnoses

and two teaching points the student might have benefited from.

The faculty performed better on all measured tasks and rated the overall performance of the patient encounter much higher when the OMP model was used. The time to use either method of teaching was exactly the same.

In contrast to the traditional method whereby a case is presented by the student, questions from the preceptor follow about patient related data, and finally the interaction is completed by a discussion on patient management; the OMP model requires a commitment from the learner about what he/she thinks is going on, thus focusing the experience. The learner is then asked to support their conclusion and to consider other options. Using this information the faculty than can assess what the learner actually understands, what they need to add to the student's learning experience, and then provide the most needed feedback.

The authors feel the rigorousness of their experimental design support their conclusions despite the lack of direct observations of student/patient interaction and randomization. An unwarranted conclusion, though, of the study was that the OMP model may be an effective method of managing patient care. There is no support or focus of this anywhere in the study.

Further Comment: Jon Fliegel, MD

Comment: The results of this nicely-done study are compelling: in the same amount of time, preceptors can diagnose patients as well or better and more effectively assess student abilities, particularly students' clinical reasoning skills. The study itself is a very good model for educational studies. To me, the key feature in the OMP model is to actually stop, take a breath and ask the learner: "What do you think is going on? Why?"

(This study actually takes on the issue of how teaching style could impact on patient outcomes. The diagnostic accuracy was similar, if not better, for the faculty who used the one-minute preceptor model. They assert that more open-ended questions of the learner might support better diagnostic accuracy.

A) Do you use the one-minute preceptor model?

B) Do you believe that the style of teaching you use could impact patient care outcomes?

C) Do you believe that the traditional model of precepting (case presented, case discussed all outside the room) is best for patient care?

D) Do you use bedside presentations when precepting students?

Steve Miller, MD)

2. Bringing Good Teaching Cases "To Life": A Simulator-Based Medical Education Service.

Gordon JA, Oriol NE, Cooper JB.

***Acad Med.* 2004; 79: 23-27**

Reviewer: Michael Barone, MD

This article provides a chronicle of a productive educational endeavor: always an enjoyable read. It is conspicuously without graphs and confidence intervals but still holds rich information. The authors detail the early, but so far successful, integration of simulator-based education into the Harvard Medical School undergraduate curriculum. They present a strong case that, given student testimonials and spreading enthusiasm, the use of simulators is a powerful and engaging means of teaching trainees, particularly in the recent climate of patient safety.

Described here is the process that led to the creation of the *medical education service,* a concept that takes a simulation center beyond simply a room with whiz-bang toys. After procurement of funding for one simulator, key steps in the process included creation of interdisciplinary oversight, appointment of a program director, partnering with the simulator technology companies, and promotion of the resource within the institution. The goal of the service is to make the simulator accessible to students and instructors at anytime. No use having a fancy model if it is collecting dust halfway across campus. To meet this goal, faculty have been recruited to be "on-call" for the simulator with the purpose of using the machine to recreate teaching cases whenever appropriate. I have to admit, this sounded a bit ambitious to me and I remain curious if such a model can be sustained. The authors, however, also describe an inventive model to have senior residents participate in teaching. Using these resources, sessions can often be arranged

"within hours to days" of the request.

I am sure many institutions are already using simulators often. Here at Hopkins, their use is currently sporadic but a simulation center is on the horizon. What will be the perfect balance of real patient exposure, standardized patients and electronic simulators to train the next generation of physicians? It will likely vary on the training setting and the specialty. While we are still in the discovery phase, future contributions of directed research and detailed reports of experiences, such as this article, will help to create that recipe.

(Simulation centers are a new and important technology for us. However, sometimes people trot out sessions that are more about showing off the method than teaching something specific and useful. Most simulators do best in teaching resuscitation and physiology. There is little or nothing related to using it to teach diagnostic reasoning, a large source of medical errors.

Do you use a simulation center to teach any competencies during your clerkship?

What would you choose to teach about first, if you suddenly had access to a simulation center?

On a scale of 1-10 – with 10 being agree strongly, do you agree that simulation will be a huge enhancement for teaching third year medical students the competencies relevant for pediatrics.

Steve Miller, MD)

3. Chin NP, Aligne CA, Stronczek A, Shipley LJ, Kacrowski J: Evaluation of a Community-Based Pediatrics Residency Rotation Using Narrative Analysis. Acad Med. 2003;78:1266-1270.

Reviewed by Randy Rockney, MD

All pediatrics and medicine-pediatrics residents at the University of Rochester Medical Center participate in a two-week community-based rotation called The Pediatric Links with the Community. Residents spend time at homeless shelters, settlement houses, soup kitchens and public schools with the hope of enhancing the residents' knowledge about community-oriented health care and expanding their understanding of community resources for poor and special-needs children. It is also hoped that such exposure will motivate the residents to assume partial responsibility for the health of children in their communities. These goals are in keeping with the American Academy of Pediatrics' Committee on Community Health Services' criteria for the practice of community pediatrics. The community pediatrician is expected to understand the sociocultural context of child health, be a committed advocate for children, and be skilled in linking families in need with appropriate community agencies and services. These are all skills that are not easily learned in an inpatient clinical setting. The effectiveness of such community experiences in achieving these recommenda-tions has not been studied. These authors used residents' self-reports in the form of short essays describing important experiences that they had had during their community rotations.

In a pilot phase, twenty-five essays selected for "the richness of the narratives and the eloquence in describing the impact of the experience on residents' learning" were analyzed by an interdisciplinary team of investigators from anthropology and public health as well as pediatrics. Three themes were identified: (1) increased knowledge regarding the lived experience of childhood poverty; (2) renewed enthusiasm for social advocacy; and (3) skill in how to refer needy families for special resources. In the study phase twenty-five additional essays were randomly selected and investigated for evidence of those same themes. In addition, the essays were examined to learn if the experience led to some transformation of the learner. Transformative learning is described as a process in which adult learners "pass through a discernible cycle of extraordinary experiences, emotional confu-sion, and reevaluation of formerly held values and beliefs." All of the essays in the study phase mentioned at least one of the three identified themes and all the essays in both the pilot and the study phase showed evidence of a transformative cycle of learning.

Comment: The overt object of the study was to assess whether a 2 week community pediatrics rotation achieved the goals and objectives formulated for that rotation. By the authors' criteria it certainly did. They do admit that the assessment cannot determine whether the rotation shaped or changed actual practice. Stated another way, this study could not measure if and to what extent "transformation," as defined above, is sustained as residents move from residency into practice.

Perhaps of more interest to us as educators, however, is the assessment tool used: qualitative analysis of learners' self-reported experiences of a particular curriculum. What is immediately evident is that such an approach can and perhaps should be

applied to a lot of the experiences we as pediatric educators offer to our learners routinely: a brief NICU exposure, child abuse clinic, the inpatient wards, etc. We have to be open to the possibility, however, that transformative experiences can be in the negative as well as the positive direction.

(I agree with Randy, that the key point of this study is how to use qualitative research to measure the impact of an educational intervention. It also addresses areas competencies, that we may or may not overtly promote during our clerkships, namely working with the sociocultural aspects of a patient's care.

1. *Have you ever used qualitative methods to assess a program?*
2. *Do you explicitly promote learning of "cultural competence" during your clerkship? If yes, what is it: seminar? Faculty explicitly developed for bedside teaching? Other?*

   Steve Miller, MD)

4. **Bannister SL, Hilliard RI, Regehr G, Lingard L. Technical skills in paediatrics: a qualitative study of acquisition, attitudes and assumptions in the neonatal intensive care unit. Medical Education 2003;37:1082–1090**

Reviewer: Bruce Morgenstern, MD (The President)

When you are Canadian, publishing in a journal out of the UK, you get to spell pediatrics in a more "worldly" way. This paper uses qualitative research tools (field observation, structured interviews and focus groups) to evaluate the acquisition and mastering of skills in an NICU. Clearly, this article is more focused on residents than students, but the observations of the authors may be generalizable.

In addition to 10 residents who were study subjects, nurses, respiratory therapists, a dietician, neonatology fellows and neonatologists were interviewed as the teacher population. The qualitative techniques identified 5 themes: feedback, opportunities, multiple demands, competing priorities, and teachers' and learners' differing perceptions.

Observations included:

1. Feedback: Residents felt that specific, detailed feedback was beneficial. When successful procedures were compared with failures, there was no apparent relationship between outcome and the content and amount of feedback.

2. Opportunities to learn: Positively factors in creating the residents' opportunity to learn included the frequency that procedures are performed, the availability of the learner *and* teacher, and the attitudes of the learner and teachers. Negative factors included competition from other learners, unstable patients or difficult procedures, negative learning climates and learners' other clinical responsibilities.

3. Multiple demands: "'Work' often interrupts 'school'." Teaching of the procedure was often interrupted by conversations about the status of other patients or by the teacher having to leave to attend to another urgency.

4. Competing priorities: The NICU setting has many competing priorities that influenced residents' choices to learn skills versus to learn and practice medicine. Competing priorities (as opposed to multiple demands) refers to the residents' decisions about whether to even attempt or seek out a procedure. "Someone asks you 'Do you want to do this?' and 'Well yeah, but no thank you.' Not a lot, but occasionally, I d have to say no. There was just too much going on."

5. Differing perceptions: Cutting across the 4 other themes, differing perceptions existed about the role of feedback, opportunities to learn, multiple demands and competing priorities between teachers and learners. Teachers world claim that they watched a resident perform a particular procedure several times before the resident was allowed independence and that they tried not to hover in order not to make the residents nervous. Learners, on the other hand, felt that they were not observed enough and would have appreciated direct and graduated supervision.

Suggestions included:

1. Recognizing that multiple demands in a busy setting interfere with immediate post-procedure feedback, staff needs to "reopen discussions" about the procedure when time allows.

2. Recognize that competing priorities affect the learning opportunities, and that a spiral of performance has been seen, wherein residents who are technically good may be sought out or themselves seek to perform procedures and, while residents who struggle with technical skills may be bypassed or seek the opportunities less often. Residents need to be explicitly informed of the expectations for procedural skills. Staff needs to understand that a choice not to perform a procedure does not always mean that a learner is lacking in initiative, but may be making thoughtful choices under the circumstances.

3. A workshop for teachers that defines the areas in which teachers and learners have conflicting perceptions and helps the teachers develop mechanisms to identify and bridge these altered perceptions.

Morgenstern comments: In many ways, the results are not at all surprising. The power of qualitative research approaches is that they can identify themes that may underlie what seems intuitive. Several themes were identified not by the authors' observations of workflow in the NICU, but as a result of the structured interviews and focus groups, and the residents or the staff had not observed them, either. Opportunities to better orient the residents and to develop the teaching skills of the staff were clarified by this approach. The opportunities also offer opportunities for research that approaches that may be more quantitative.

On another level, I was not cognizant of these themes. I may have noted the issues as they apply to my work as attending on our General Pediatrics inpatient service, but not this well organized. This may help me better approach my orientation to the students and my efforts to work with residents as teachers.

(Another example of qualitative research. Once again, the difference between how learners and teachers see the same thing is amazing. How do you keep track of what the "scuttlebutt on your clerkship is?

Do you have someone other than yourself debrief the experience in a focused group style?

Do you think this should be done for all clerkships?

Steve Miller, MD)

5. Developing culturally competent community faculty: a model program. Ferguson WJ, Keller DM, Haley HL, Quirk

M. *Acad Med* 2003;78(12):1221-8.

Reviewed by Su-Ting Li, MD; UC Davis

This article describes a cultural competence curriculum for training community preceptors. The cultural competence training is integrated into a community faculty development program, Teachers of Tomorrow program, which is a series of four, two-day workshops spread out over 18 months. The cultural competence portion of the curriculum consists of four 2.5 hour modules combining interactive lectures, and large and small-group role-playing exercises. The paper reports on the curriculum and the experiences of the 137 community preceptors from 15 medical schools in New England and New York who have participated in the first two years of this program.

The Curriculum: Workshop 1 focused on doing a cultural needs assessment of your student based on a simplified ethnosensitivity scale, with the lower end of the scale being learner-centered (egocentric), the middle of the scale being minimalist (treat everyone the same and minimize the importance of culture), and the upper end of the scale being patient-centered. Workshop 2 focused on teaching patient-centered interviewing using a modified LEARN mnemonic (Listen, Elicit, Assess, Recommend, Negotiate). Workshop 3 focused on planning community-based learning experiences for students and Workshop 4 focused on how to observe and give feedback to students using the "plus/delta" tool about what are positive behaviors and what are behaviors that need to change.

The Experiences of the Preceptors: Overall, the

community preceptors appeared to value the cultural competence curriculum, with mean scores of 4.11 and 4.36 on a 5-point Likert scale. The most interesting part of the study was measurement of each participant's self-reported intention to change and self-reported changes to teaching cultural competency based on the program. Workshop 2 (and the LEARN mnemonic) appeared to make the most impact, with 48.1% of preceptors reporting that they intended to make changes after Workshop 2 and 21.4% reporting that they actually made changes to their teaching behaviors!

Comment: As our patients and students come from more and more diverse backgrounds, cultural competence training becomes even more important. I'd be interested in hearing more about the LEARN mnemonic and finding out a year or two out if the community preceptors are continuing to use this tool with their students.

Do you teach an explicit model of cultural competence in the approach to specific patients, such as LEARN or the Kleinman Model? If yes, which one do you use?

Steve Miller, MD

6. "Effect of an Undergraduate Medical Curriculum on Students' Self-directed Learning"

BJ Harvey, AI Rothman, RC Frecker,

***Academic Medicine* 78:1259-1265, 2003.**

Reviewer: William G. Wilson, MD

These authors describe the effect of a curriculum modification at the University of Toronto on self-directed learning (SDL) by medical students, as defined by responses to 3 questionnaires designed to assess SDL. Students in each of the 4 years of medical school were randomly surveyed, and the responses between the class years were compared to determine if there were differences that might reflect effectiveness in the curriculum in developing SDL skills. Overall, there were no significant differences in the responses to the questionnaires among the 4 classes. This suggested that SDL was not impacted by the revised curriculum. There were differences between students with Ph.D. degrees and those with either undergraduate or Master's degrees; those with Ph.D. degrees scored higher on the SDL questionnaires than the other groups. There was also a trend toward a diminishing view of the importance of SDL as students progressed through medical school.

I found this study both refreshing and disheartening-"refreshing" because the authors published a negative study, one whose results did not validate a curriculum change. (I sometimes wonder how many "negative studies" go unreported or unpublished, therefore shedding light and perhaps unwarranted attention on those published studies that yield positive results). But I also found it disheartening that a curriculum designed to improve these skills in the medical students was ineffective. The authors offer several alternative explanations for their observations, but felt that the results were accurate and reflected a lack of effectiveness of their curriculum on developing these skills.

(This is an interesting article, the background includes a statement that medical students have scored more highly than other professions in this area –

Do you think that your curriculum fosters self directed learning?

Steve Miller, MD)

7. Critically Reflective Practice

Brookfield, Stephen

J Continuing Education in the Health Professions 1998; 18: 197-205

Reviewer: Larrie Greenberg, M.D.

As practitioners, we often lose sight of one of the major purposes of CME; namely, to translate cognition into practice. This change process results in better care for our patients and better education for our learners. The article I chose to review has done just that for me; i.e., it has given me a more organized overview of my educational efforts. That is why I chose to share this article with my COMSEP colleagues.

Brookfield defines critically reflective practice as 'the process of inquiry involving practitioners in trying to discover, and research, the assumptions that frame how they work.' Reflective practitioners

review these assumptions by seeing practice through 4 lenses: 1) those of their own anecdotal, rich life experiences; 2) those of their learners; 3) those of their colleagues; and 4) those of the literature. Assessing practice without considering all four lenses is incomplete, in my estimation. Viewing what we do through these lenses allows us to assess who we are and how we come across to others.

Let me briefly summarize each of the lenses. The first, one's autobiography, allows us to reflect how it was for us as learners and to use that information as we engage learners. Our memories as learners of what didn't go well for us are most likely going to lead to better connections with learners whom we engage.

The second, the lenses of our learners, allows us to view the world like we haven't viewed it previously. If our learners are honest, we can learn a great deal about ourselves. This only happens in a trusting environment.

The lens reflecting our colleagues' experiences helps us learn others' perceptions of why things happen the way they do. Talking about problems in common with suggested solutions is what COMSEP is all about; i.e., a collaborative and not competitive environment so that all of our students benefit.

Finally, the fourth lens is the 'best practice' or evidence-based literature. When we combine the other lenses with what is documented in the literature, we gain added credibility with our colleagues who are skeptical about medical education.

As a way to evaluate critical reflection, Brookfield suggests asking 5 questions to our learners:

- At what moment in this learning experience were you most engaged as a learner?
- At what moment in this learning experience were you most distanced as a learner?
- What action that anyone on the team took was most affirming or helpful?
- What action that anyone on the team took was most confusing?
- What surprised you most about the class (or rounds, clinic experience) this week (month, day)?

(These 5 questions could really help improve our teaching, I wonder if this would be a better form to have learner's fill out – to provide feedback to teachers.

Would you use these 5 questions in an evaluation/feedback form for teachers?

Steve Miller, MD)

8. Do Clerkship Directors Think Medical Students Are Prepared for the Clerkship Years?

Donna M. Windish, Paul M. Paulman, Allan H. Goroll, and Eric B. Bass

Academic Med 2004. 79(1): 56-61.

Reviewer: Sherilyn Smith

Background: The purpose of current study was to assess clerkship directors' perceptions of student preparedness in the area of six core competencies, similar to those described by the ACGME for residency training. The core competencies outlined in this study were: communication skills, interviewing/physical examination, professionalism, clinical epidemiology and probabilistic thinking, understanding systems of care and understanding a patient's life-cycle stage.

Methods: A survey was sent to a randomly selected subset of clerkship directors in the fields of pediatrics, internal medicine, family medicine, obstetrics/gynecology, surgery and psychiatry. Demographic data about the clerkship directors and the respondent schools were collected. Directors were asked to rate the level of ability (none, minimal, intermediate, advanced) in each of 6 areas that students should have when BEGINNING clerkships. Directors were also asked to estimate how prepared they felt their students were (much less prepared than necessary, less prepared than necessary, at the level they should be, more prepared than necessary, much more prepared than necessary) in these 6 areas.

Results: Thirty-two schools were selected and the survey response rate was 74%. Schools in the West/Southwest and surgery clerkship directors were less likely to respond. Clerkship directors supported the notion that the articulated

competencies were "core" and most frequently cited interviewing/physical examination (32%) and communication skills (21%)as important. Their views on the level of skill in each of the competencies and the degree of student preparedness is outlined below:

Life cycle stages	55%	30%
Healthcare systems	30%	40%
Epi/Reasoning	60%	50%
Professionalism	95%	30%
Interview/PE	80%	45%
Communication	95%	30%
Directors Perception	Intern/Advanced/skills needed	Less prepared than needed

There was little variability in responses according to specialty or years teaching. Those with more experience teaching in the pre-clinical years felt students needed intermediate/advanced skills and were less well prepared in the area of interviewing/PE. Those with a higher percentage of time in the outpatient setting were more likely to report that students were less prepared than necessary in epidemiology/probabilistic reasoning.

Comments: This is an interesting study that begins to address what skills should be taught throughout the 4 years of undergraduate medical training. There was consensus about the content (98% of respondents agreed with the 6 core competencies). A high proportion of the respondents felt that students should have advanced skills in 3 of the 6 competencies and that a significant portion of our students are not adequately prepared in these areas. Students may need less advanced skills in the other areas but their preparedness is still inadequate. What is missing from this article is a better description of the competencies. I am unsure what knowledge/skills/attitudes students should have in communication skills or life-cycle stages. I also wonder what "intermediate or advanced skills" means and what the level of preparedness means. Inclusion of these definitions would make the generalizability of the article clearer. The next steps then might be developing specific curricula, benchmarks and expectations/evaluation materials for these areas in a developmentally appropriate manner. Perhaps, if students are appropriately prepared in these "core competency" areas, they may be better able to assimilate new knowledge and skills during their clinical rotations (although this hypothesis needs to be tested!)

(The underlying rationale for this study, was to generate an imperative to enhance medical student preparedness for the major clerkships.

Do you believe that medical students at your school are adequately prepared for the major clinical clerkships when they begin their major clinical year?

Would you advocate for more clinical training prior to starting the major clerkships at your school?

Steve Miller, MD

The following are a few more studies, briefly described, that are worth mentioning:

1. **Responding to the ACGME's Competency Requirements: An Innovative Instrument from the University of Virginia's Neurology Residency**

Karen C. Johnston, MD, MSc

***Academic Medicine* (2003) 78: 1217-1220**

This is a descriptive article of a tool for self assessment and faculty assessment. It has objectives listed and the 6 ACGME competencies across the top. Faculty are trained to score an objective, like perform a complete neurological exam, across the 6 domains (eg. medical knowledge – score them on the knowledge aspect of the exam, communication, professionalism etc). Take a look a this tool.

Do you think this adds a measure of explicitness to evaluation that would be useful for students?

2. Medical Student Evaluation of the Quality of Hospitalist and Nonhospitalist Teaching Faculty on Inpatient Medicine Rotations
Alan J. Hunter, MD, Sima S. Desai, MD, Rebecca A. Harrison, MD and Benjamin K.S. Chan, MS
***Academic Medicine* (2004) 79: 78-82.**

The title speaks for itself.
Do you think Hospitalists provide equal teaching to that given by the traditional inpatient teaching attending and team?
There answer is yes – and maybe even better.

3.Teaching Points Identified by Preceptors Observing One-Minute Preceptor and Traditional Preceptor Encounters
David M. Irby, PhD, Eva Aagaard, MD and Arianne Teherani, PhD
Academic Medicine (2004) 79: 50-55.

This is a fascinating study. Preceptors viewed tapes of students presenting in either the traditional model or using the one minute preceptor model (focuses on asking the student, what would you do and why) and were asked to list their teaching points to the student. Preceptors taught more about decision making and reasoning if they viewed the one-minute preceptor and addressed generic skills like the presentation or history taking when they viewed the traditional tape.
After hearing this, would you be more inclined to vary your approach so you could teach about and observe different skills of the learners?

4. To Be and Not To Be: The Paradox of the Emerging Professional Stance.
Ginsburg S, Regher G, Lingard, L
Med Ed 37, 350-357

This is a fascinating study – that looks at student narratives describing lapses in professionalism. Students describe being in a "double bind" – in which they must choose to intervene to prevent the lapse, or maintain cohesiveness in front of the team or patient. The authors state that most narratives reveal that students vacillate between action and dissociation (which facilitates non action).The take home point? Students need specific strategies for trying to go beyond the two choices – each which is inadequate – and be able to act in a way that maintains the trust of the patient.

Do you explicitly teach about Humanism and or Professionalism in your clerkship?

Hope to see everyone in Florida at the COMSEP Meeting
March 5-March 8, 2004