The Pediatric Educator

Vol. 3 Issue 1 SUMMER 1995

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A MESSAGE FROM THE PRESIDENT

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President's Corner - COMSEP

Having successfully completed our meeting with the pediatric chairs in March, we should all feel proud of how COMSEP has developed and received recognition as a significant force in pediatric education. I would like to provide profiles of three members of our organization who have helped us reach our present position. They are role models who have attributes and characteristics from which we all can learn. I choose these three clinician/educators as examples; there are many more in COMSEP whom I could choose would space allow.

Profile no. 1: **Rich Sarkin**

Rich is currently the clerkship director at Buffalo Children's Hospital and became interested in education early in his career, having taught 7th grade at one time. He has developed an insatiable appetite for the process of medical education and this yearning to make the system better has led him in a number of directions. In the late eighties he teamed with a Buffalo school teacher to begin his work in faculty development, and is the first educator of whom I am aware who uses excerpts from movies to illustrate teaching and learning models. The beauty of using movies as a way to initiate discussion about medical education is that it neutralizes the content and keeps teachers and learners focused on the process. His charisma, enthusiasm and love for his work create a catharsis in his audience similar to the effect of a Shakespeare play or a Billy Graham revival.

Rich has been recognized by the medical school and his department as an outstanding clinician/ educator and he continues to set high goals for himself. Currently, he is pursuing a master's degree in education. I assure you that this isn't for the sake of putting extra letters behind his name. My perceptions are that he just can't get enough education to broaden his horizons. Rich Sarkin is an individual who wants to make things better. He does it with a joie de vivre and an enthusiasm few can match. Just ask the people he's touched.

Profile no 2: **Ben Siegel**

Ben has been the clerkship director at Boston City Hospital (Boston University Medical School) for eighteen years and has had an interest in education for a long time. I first met Ben in the early eighties when a group of us from the Ambulatory Pediatric

Association (Paula Stillman, Scott Obenshain, Floy Helwig, and myself) set out to write the undergraduate curriculum in general pediatrics, the first of its kind . Our plan was to divide the work into sections, with each of us writing objectives and competencies for those sections and presenting them to the entire group for feedback. Through working with him, I came to understand Ben Siegel as a caring, compassionate advocate for children and their physicians. This advocacy is clear when he talks about the importance and complexity of the doctor-patient relationship: its basis in clear communication, the relevance of cultural and ethical sensitivity and the needs of physicians as well as patients. Ben not only loves to teach these concepts, he demonstrates them in his professional practice. He reminds us (when we often forget) about the importance of these issues as an integral part of our professional responsibilities, not as some secondary thought. How he has incorporated some of these issues into his clerkship and work within the medical school is an example for us all to emulate.

Profile no. 3: **Jennifer Johnson**
Jennifer is quiet, unassuming and humble . . .but this is a physician that is goal-oriented and gets the job done. My friendship and professional relationship with Jennifer is shorter than with Rich and Ben but just like Bo knows football, I know Jennifer! She has almost solely been responsible for initiating, implementing, and administrating COMSEP's Resource Clearinghouse. This is staffed and supported on a shoestring and exists because of Jennifer's perseverance, willingness to take chances, and to ignore the skeptics who were pessimistic this notion could ever succeed. I humbly admit that I initially told Jennifer the idea was great but how could it happen given all the limitations? Well, she showed me and other 'experienced' educators that 'if you wish it, it's no legend,' a quote from Theodore Herzel, who advocated for a Jewish homeland in the nineteenth century but never lived to see the state of Israel. She has continued this attitude of the glass is half-full, not half-empty in her work as clerkship and residency training program director at the University of California, Irvine. Her brief presence there has significantly improved the residency training program and recent efforts have led to an exciting faculty development program directed toward chief residents across disciplines. You've taught me a lot, Jennifer and I thank you for leading the way.

As a final note, very few of us work as hard as we do or as effectively as we do because of external reward systems. However, it is nice to have our efforts validated publicly as an additional stimulus to keep on truckin'. I not only salute my three colleagues in this column, I recognize all of you who labor in the trenches with our physicians of the twenty-first century. Know you're appreciated!!

Lastly, since none of the above were notified in advance of my remarks, I apologize if there are any errors or misperceptions in my comments. They all came from my heart, accurate or not!

INSIGHTS IN MEDICAL EDUCATION

Developmental Concepts In Education

Albert P. Scheiner
UMass Medical School

There are few professional and personal roles that I have enjoyed more than that of medical educator. My experience as an educator has given me the opportunity to use my skills and knowledge as a developmentalist and to elaborate upon my interest in the well being of children.

As a teacher, I have become increasingly aware that the education of students and colleagues draws heavily upon the developmental concepts of such scholars as Piaget, Mahler, Erickson and Dewey. The developmental concepts that they discovered and espoused are relevant to the educational process. The establishment of trust with our students initiates and facilitates the learning process that results in a gentle, capable and understanding physician. The abused student, on the other hand, much like the abused child, becomes an abusive physician. By identifying and respecting the individual characteristics of our students and focusing on their best qualities, we provide them with a

sense of security and identity which permits them to enjoy the richness of medicine. Unlike children, they bring a maturity to the learning environment that contributes to their growth as well as the growth of their teachers. The development of trust and the excitement of discovery ultimately express themselves in the students' independence and competence, and these are the nutrients of the soul of the educator.

The council on Medical Student Education in Pediatrics (COMSEP) started approximately eight years ago when many of us came together for the purpose of enhancing medical student education in pediatrics. As a group, we learned that we could trust one another to be available for the support of new ideas and clarification of old thoughts. During this period, we sought the approval and support of our caretakers, our chairpersons. We sought out caretakers that we knew we could trust to help the members (children) grow professionally while enjoying the enthusiasm of self-discovery. Unlike many organizations in medicine, we have promoted the inclusion and support of our members and have been enthused by their growth, independence (separation and individuation) and achievements.

As pediatricians we are all aware of the principles of trust, the importance of significant others and the importance of adult models. Our students and COMSEP have both benefitted from these principles and I feel proud and privileged to have had the opportunity to participate in the growth of our students and the development of COMSEP. As a good parent, it is time for me to step aside while maintaining a watchful eye and continuing to care. I will continue to offer guidance when asked and occasionally when not asked.

I thank you for the opportunity to serve as the editor of The Pediatric Educator and for tolerating my sometimes tardy publications.

HIGHLIGHTS FROM THE AMSPDC/COMSEP MEETING

This past March 11-13, COMSEP held a joint meeting with AMSPDC in San Diego. The following are summaries of the Task Force Committees and the abstracts of original papers presented at the meeting.

Teaching Methods/Faculty Development Task Force

Karen Wendelberger-Chairperson

First, the Task Force discussed its past accomplishments. Requests were made for input from anyone in COMSEP to aid in the update of the Resource Manual for Faculty Development. Suggestions can be sent to Karen Wendelberger by mail, FAX, or E-mail (kwendel@post.its.mcw.edu).

Second, as a project for the upcoming year, we agreed that implementing the Curriculum should be of primary importance. Suggestions of ways to accomplish this goal included the following:

"Train the Trainers Workshop"- To be provided at the 1996 COMSEP meeting for the first time, this workshop will aid clerkship directors in becoming more skilled in giving faculty development workshops. (Team leaders: Richard Sarkin, Jennifer Johnson, and Steve Blatt).

"The Whole Teacher's Catalogue"- This handbook will identify teaching strategies and suggestions for when and how these strategies could be used. (Team leaders: Janet Fischel and Jennifer Johnson).

"The Educator's Portfolio"- Documentation of productivity as educators is one of the keys to academic acceptance and success. The use of a portfolio or dossier system has been demonstrated as useful in several schools. COMSEP has been approached by the APPD to join with them in helping clerkship and program directors to take the lead in creating their own portfolios and facilitating their creation and use by other educators. (Team leaders: Karen Wendelberger and Donna Elliot).

"Computer Software and Us"- The increasing availability of computer assisted teaching methods will be (hopefully) addressed by the Informatics Task Force. Bruce Greenberg will keep us updated on its progress. Finally, a suggestion was made to develop a "resource list" of people willing to accept calls and help out new (and not-so-new) clerkship directors with a variety of issues. A listing will be submitted to The Pediatric Educator.

Evaluation Task Force

Roger L. Berkow-Chairperson

The COMSEP Evaluation Task Force met on March 13, 1995. First, Ben Siegel, who has chaired this Task Force for the last three years, indicated that he was stepping down from the Executive Committee at this time and asked for volunteers to lead this Task Force over the next several years. Roger L. Berkow from the University of Alabama at Birmingham, who is beginning his term on the Executive Committee this year, volunteered to take the lead .

The Task Force then discussed the monograph on evaluation which is part of the resource manual for the general pediatric clerkship curriculum. We felt that, although this was a valuable document, it was only the beginning of the work on evaluation. Several topics emerged from our discussion, including evaluation of the new curriculum, measured outcomes of the new curriculum and evaluation of revisions in the new curriculum.

We next discussed how to use the curriculum to drive evaluation of students as opposed to allowing evaluation to drive curriculum as currently occurs in many places. The Task Force felt that the development of a national comprehensive examination, based on competencies and objectives within the core curriculum, was a desirable and realistic goal. We hope to work with the National Board of Medical Examiners, using the curriculum and core competencies for the development of multiple-choice of questions for national use. Specifically, we hope to develop a series of questions based on the clinical vignettes which are described in the clinical problems section of the curriculum supplement. Also, we will be working on a computer based examination which we believe would have widespread appeal. The Task Force felt that COMSEP's associations with other academic societies such as the American Academy of Pediatrics and the American Association of Medical Colleges need to remain strong and that these bodies need to be aware of the curriculum and to be kept updated about progress in evaluating its implementation. As implementation takes place, the Task Force feels that long-term tracking of the ability of this curriculum to change approaches to clinical skills, attitudes and career goals is necessary.

The Task Force indicated a need for an addition to the resource manual dealing with peer and self-evaluation techniques. This project was assigned and will be forthcoming within the next year. Similarly, a large number of Task Force members were interested in the development of a national bank of clinical scenarios and OSCE stations. Such a resource would be helpful, allowing the use of the same scenarios and stations across many campuses, thereby permitting interdepartmental comparisons as well as research in the areas of evaluation.

At the close of the meeting the following subcommittees were developed to begin addressing these questions: a subcommittee on OSCE; a subcommittee on evaluation of students in community settings; a subcommittee for long-term tracking and outcomes issues; a subcommittee for linkage with national academic organizations; a subcommittee for development of evaluation tools to be used by students and attending physicians regarding the new curriculum; a subcommittee for development of a national exam based on core competencies with linkage to the National Board of Medical Examiners; a subcommittee on implementation of the curriculum; a subcommittee to develop a baseline survey to evaluate the who, what, when, where and how of current curriculums and then, later, of the new curriculum; and a subcommittee to develop a monograph on self and peer evaluation A list of the "chairs" of the respective subcommittees, brief goals and rough time lines for accomplishing some of these goals follows.

Members of COMSEP who wish to participate in any of these subcommittees, but who did not attend the Evaluation Task Force meeting, are certainly welcome to contact the chairperson of the subcommittee who will welcome their participation.

COMSEP Evaluation Task Force

Subcommittees

(Only Chairs or Co-Chair Listed)

OSCE

Co-Chairs--Lindsey Lane.
Medical College of Pennsylvania
215-842-7649

Tracy Lower-

S. Illinois University
217-782-7732
Goal: Collect pediatric OSCE stations, including student and simulated patient instructions and score sheets. Time frame: 1 year.

Evaluation of Students in Community Setting
Co-Chairs-- George Johnson--
Univ. of N. Dakota
701-293-4109
Bob Janco--
Vanderbilt
615-322-7475
Goal: Review literature, collect evaluation methods and forms; prepare monograph for resource manual. Time frame: 1 year.

Long-Term Tracking and Outcomes
Chair--Tom DeStefani-
Loyola
708-327-9075
Goal: Develop liaisons with clerkship directors to determine how students perform with relation to core competencies in Pediatrics. Determine whether and how the core curriculum influences student behaviors. Time frame: long term 5-7 years.

National exam based on core competencies
Linkage with National Board of Medical Examiners

Co-Chairs--Roger Shott-
Univ. of Louisville
502-629-8626
Ben Siegel-
Boston Univ.
617-534-5576
Goal: Begin the development of a national multiple choice exam based on the core competencies which will be administered through the NBME. (Liaison with Susan Case, Ph.D. at NBME). Time frame: 2-3 years for implementation; 4-6 years to evaluate result of exam in relation to historical data.

Evaluation of New Curriculum By Students & Attendings
Co-Chairs--Dan Stewart-
Univ. of Louisville
502-629-8626
Omer Berger-
Univ. of Cincinnati
513-559-4506
Goal: Develop a survey which can be distributed to a sample of senior medical students, pediatric residents, and pediatric attendings to determine:

1) If these groups believe the competencies are appropriate,

2) If competencies are currently being covered in pediatrics,

Evaluate students after several years of implementation to review these issues.

Time frame: 1 year with follow-up survey later.

Linkage with AAMC,AAP
Co-Chairs--Mike Lawless-
Bowman Gray
910-727-8108
Roger Shott-
Univ. of Louisville
502-629-8626
Goal: To keep other academic organizations appraised of the new curriculum. Time frame: ongoing.

Implementation of Curriculum
Chair- Tom DeStefani-Loyola
708-327-9075
Goal: Develop evaluation of methods to assess how, when, and where the new curriculum is being implemented. Time frame: 2 years

Baseline Survey
Co-Chairs--Roger Berkow-Univ. of Alabama at Birmingham
205-939-9285
Ben Siegel-
Boston University
617-534-5576
Goal: To develop a survey to determine 1) if the competencies outlined in the curriculum are currently being taught; 2) how they are being taught i.e. computer, lecture, small group, patient exposure, etc.; 3) by whom they are being taught: resident, faculty, nursing staff, nutritionists, self-directed; 4) where are they being taught -ambulatory clinic, in-patient wards, community clinics, etc. Time frame: 1 year.

Monograph On Self and Peer Evaluation
Co-Chair- Michael Rieder-
Univ. of Western Ontario
519-685-8293 x519
Nicholas Jospe--
Univ. of Rochester
716-275-7744
Goal: Review literature and write monograph on this topic for inclusion in resource manual. Time frame: 1 year.

Curriculum Task Force
Ardis Olson-Chairperson

Seventeen members met to

consider the next activities of the task force now that the general pediatric curriculum and task force are a reality. Issues raised for the task force activities included: examining ways to integrate the curriculum into other years of medical school training, assisting schools with implementing the curriculum, developing integrated units from the curriculum that combine the curriculum with learning resources (eg. PREP, Pediatrics in Review), working in collaboration with the NBME to establish pediatric student testing that is based on the new curriculum and establishment of mechanisms to evaluate nationally the specific outcomes resulting from the new curriculum.

The group agreed to recommend that the organization contact Susan Case of the national board and offer to work collaboratively towards exams that reflect the new curricular content.

The outcome of curriculum implementation nationally was felt to be a key activity with focus on reporting progress back to AMSPDC chairs in 3 years as well as continuing to follow changes over 5 years. This activity will be in collaboration with the evaluation task force. Sources of assistance include the AAP, Educational consultants (David Irby of the Univ. of Washington, Linda Gunzberger of Chicago Medical School). Linda Manfred joining the task force from U Mass also has a doctorate in education with a background in evaluation.

Discussion of baseline data to be obtained focused on gathering data of both process and final outcomes. data will need to be obtained at the individual student level, program level, medical level and national level.

Potential data to be gathered could parallel many of the areas that programs would use as a needs assessment at the start of local implementation. Additional ideas for baseline data for each area are:

Student level- observed history and physical, clinical problem solving, step 2 performance in pediatric questions.

Program level- number of faculty involved, use of ambulatory and community based sites, faculty development programs, role of generalists

Institutional level- integration of pediatric objectives into other courses

Process outcomes- demonstration of involvement of chairmen and other faculty in the process, curricular planning process in place, involvement with the chapter AAP re: community MD involvement.

It was recognized that some variables would need to be evaluated broadly across all schools but specific student level outcomes would be obtained at fewer schools. The focus on schools that were implementing change in key areas could allow pre and post assessment in those areas. For example, implementation of a common problem approach with active teaching of clinical approaches could examine whether those students do better in a clinical problem solving exercise. Provision of a new learning unit on one of the content areas to certain schools could show better knowledge in exams.

The next step will be the development of a detailed evaluation plan with evaluation expert input. It will focus on assessing curriculum status nationally at baseline and develop further supports for evaluation.

ABSTRACTS OF ORIGINAL PAPERS PRESENTED AT COMSEP MEETING

HOW DOES THE PEDIATRIC CLERKSHIP AFFECT STUDENT ATTITUDES TOWARD PEDIATRICS AND THE DECISION TO CHOOSE A CAREER IN PEDIATRICS?

Paul Kaplowitz, M.D., Russell Boyle, M.D., Jiandong Lu, Ph.D., Medical College of Virginia, Richmond, Virginia.

One of the challenges faced by medical educators in pediatrics is to make a career in pediatrics attractive to students in our clerkships. A survey administered before and after our pediatric clerkship was designed to identify how seven specific attitudes towards pediatrics are changed by the experience of the clerkship (using a 5-point Likert-type scale), and how these changes relate to interest in a pediatric career. This survey was presented to clerkship directors at the March 1992 COMSEP meeting and 11 programs ultimately participated; matched pre- and post-clerkship surveys were obtained from 1161

students (68 %) during the 1992-'93 academic year. Results revealed that the proportion of students strongly agreeing with an interest in a pediatric career was much higher for women (11% pre-clerkship vs 22% post-clerkship) than for men (3.9% vs 10.9%). As expected, attitudes towards pediatrics were more favorable after the clerkship than before. The two items for which a change in score correlated best with a change in interest in a career m pediatrics were: "Children are enjoyable to work with" and "Pediatricians are nice people to work with." Students were also asked on the post-clerkship survey to rate different aspects of the clerkship. The highest mean scores were given to interactions with inpatients and ward residents, while the lowest scores were given to private practice preceptors and lectures. The rating of ward residents correlated most strongly with an increased interest in a pediatric career. The results of this survey have important implications for changes which are most likely to help with recruitment of students into pediatrics (e.g. more effort spent on teaching residents to teach). In addition, they have allowed the participating schools to compare their ratings with other schools and thus identify areas of strengths and weaknesses in their programs.

INSTRUCTIONAL STRATEGIES MAY AFFECT THE ACQUISITION OF PHYSICAL DIAGNOSIS SKILLS
Beth Ellen Davis, M.D., Gregory J. Toussaint, M.D., Louis I. Cooper, M.D., Joseph 0. Lopreiato, M.D., Uniformed Services University of the Health Sciences, Bethesda, Maryland.

Purpose: To examine whether differing instructional strategies in a physical diagnosis (PD) course affects student acquisition of PD skills.

Methodology: All 168 second year students in our Introduction to Clinical Medicine course constituted the sample population. Students received three hours of classroom instruction in pediatric PD. Students were then assigned alphabetically to three groups. Group 1 (55 students--33%) participated in a structured, community based exercise, involving physical examinations of a toddler and a newborn. Group 2 (49 students- -30%) was assigned to hospital based physicians provided with objectives for the afternoon block. Group 3 (64 students--37%) received only the classroom instruction and served as controls. Three weeks later, an OSCE, highlighting PD skills presented during the course, measured students' acquisition of exam skills. Physicians, blinded to student groups, used a checklist to record student performance. Descriptive statistics and chi-square analysis were used to interpret the data.

Results: Graded responses to fifteen of the twenty test items were not statistically different between groups. However, when performance of a specific motor skill (examination of a newborn hip) was assessed, students in Group 1 and 2 were twenty times more likely to correctly perform this skill than controls (p=.0001). Furthermore, Group 1 performed this skill four times better than Group 2 (p=.O1).

Conclusions: PD skills can be taught by a variety of instructional methods. However, certain skills are best learned using structured, supervised curriculum rather than traditional lectures, demonstrations or informal hospital visits.

STUDENT EVALUATIONS OF FACULTY: A COMPARISON OF TWO METHODS
Michael J. Rieder, M.D., David Warren, M.D., David Lloyd, M.D., University of Western Ontario, London, Ontario.

Evaluation of faculty by students is a routine component of course evaluation. The optimal method of evaluating faculty in a clinical setting, when students see large numbers of faculty for relatively short periods of time, has not been established. We compared two methods of evaluation among students completing a six week clerkship in pediatrics during their third year of undergraduate medical studies at the University of Western Ontario. Thirty-two students participated in this research. At the conclusion of the clerkship, students were randomly given one of two evaluation forms to complete. The first form listed all faculty with a visual analogue scale (VAS). Students were asked to provide a VAS score for those faculty they felt comfortable evaluating. The second form was a Scantron computer form which listed 20 different teaching attributes as well as an overall score; students were asked to

complete a form for those faculty they felt comfortable evaluating. Students were given a list of all faculty. After they had completed the first evaluation, students completed the second.

Significantly more faculty members were evaluated using the VAS score than using the Scantron form (48 versus 21, $p < 0.05$). Among the faculty members evaluated, there were significantly more evaluations provided in the group evaluated by VAS than by the Scantron forms; 50% of the VAS scores had six or more evaluations per faculty member, compared to 14% of the Scantron forms ($p < 0.05$). No faculty member evaluated by Scantron forms had more than eight evaluations; in contrast, there were six faculty members evaluated by the VAS scale who had more than 20 evaluations each. Although there was general agreement in ranking of faculty between the two forms, there were certain major differences. The faculty member who achieved the highest VAS score (8.0 out of 10, n=14) was not evaluated on any of the Scantron forms, while the instructor who received the lowest evaluation (4.2 out of 10, n=12) received a mid-range evaluation on the Scantron forms. Among the Scantron forms, there was good overall agreement among the 20 attributes listed and the final score assigned by students.

Our data suggests that student evaluations of faculty are dependent on the type of evaluation used, and that the goals of evaluation should be considered when selecting the type of evaluation. If the goal of evaluation is to provide information on components of individual teaching behavior, then the use of multiple questions, as on the Scantron forms, may be appropriate. However, if the goal of evaluation is to identify exceptional teachers, both good and bad, and to provide reliable information with respect to how individual instructors compare, then the use of scales such as the VAS may be more appropriate.

CLERKSHIP DAY 1: TEACHING STUDENTS SURVIVAL SKILLS

Gregory J. Toussaint, M.D., Beth Ellen Davis, M.D., Louis I. Cooper, M.D., Joseph 0. Lopreiato, M.D., Uniformed Services University of the Health Sciences, Bethesda, Maryland.

Orienting students to a clinical clerkship usually involves explaining responsibilities, grades, and lecture schedules. This time may also be used to teach valuable skills. We developed and evaluated a method for teaching third year students key "survival skills" during the clerkship orientation morning.

Methods: Using a standardized curriculum, small groups of students rotated through four 25 minute skill stations led by a faculty member or resident. Each station covered one of four topics: the approach to examining an infant or toddler; interpreting growth charts and vital signs; assessing development through observation; and pediatric prescription writing. Students took a five section, ten point pretest prior to the skill stations to assess their baseline knowledge of the material. One week into the clerkship, the students took a reordered, but otherwise identical posttest to assess retention of material presented during the clerkship orientation morning. Data was collected over one academic year.

Results: Analysis of matched pre and posttests (N=51) showed an increase in the mean total score from 5.98 to 8.16 (p=.OOO1). Significant improvement occurred in all five subsection scores (all p<.02). To determine whether area of assignment for the first week of the clerkship affected retention of material, we compared posttest scores (N=95) of students assigned to outpatient or inpatient areas. No significant difference existed between total or subsection scores (all p>.1 5). Completion of a Family Practice rotation prior to Pediatrics did not significantly influence pretest knowledge, except in the prescription writing subsection (p=.03). In end of course critiques, students rated the skills presented during the orientation program as highly useful during the clerkship.

Conclusions: We demonstrated a simple and effective method for teaching critical pediatric skills to medical students on the first day of their clerkship. Students retained these skills regardless of the sequence of subsequent clinical responsibilities.

PEER REVIEW AS A METHOD OF ASSESSING THE CLINICAL PERFORMANCE OF MEDICAL STUDENTS

Michael J. Rieder, M.D., University of Western Ontario, London, Ontario.

Despite considerable effort, the optimal method of evaluating the clinical ability and performance of undergraduate medical students remains uncertain. Although widely used in other areas, including decisions regarding publication and grant funding,

peer review has rarely been used to evaluate the clinical performance of undergraduate medical students. We conducted a pilot project to compare peer reviews with evaluations by faculty members to assess the clinical performance of medical students. During their six-week rotation in the Pediatrics Clerkship at the University of Western Ontario, 37 clinical clerks participated in this study. There were three blocks of 12, 12 and 13 students per block. At the conclusion of their six week block, all clinical clerks completed a peer evaluation of the other clerks on the block. The results of the peer review were compared to the evaluations of the clinical clerks made by the attending faculty. With respect to grades, the peer review assigned fewer honors (0 compared to 10% assigned by faculty) and more marginal/failing grades (5% compared to 0 assigned by faculty). With respect to specific comments, peer review provided significantly more comments than did faculty (331 versus 78, $p<O.05$). When the comments were analyzed into those which provided useful feedback and those which were essentially meaningless, there was an equally striking difference between peer review and faculty (66% useful comments by peer review, 36% by faculty, $p<0.05$). Similar percentages of the useful comments by both groups reflected positive feedback (52% peer review, 42% faculty) and areas for improvement (48% peer review, 58% faculty). This suggests that undergraduate medical students are more critical assessors of their peers than are faculty and are more likely to provide useful feedback. Further studies on the utility of peer review as a means of evaluating the clinical performance of undergraduate medical students are necessary.

CLINICIANS AS TEACHERS: THE USE OF TEACHING "SCRIPTS" Karen Wendelberger, M.D., Deborah Simpson, Ph.D., Medical College of Wisconsin, Milwaukee, Wisconsin.

Little is known about how academic physicians, who are often required to teach, become good teachers. Shulman and others demonstrated the use of "scripts" by formally trained educators. These scripts contain goals of instruction, key teaching points, recognition of learner abilities and strategies used to teach in certain settings. Recently, Irby became the first to identify the use of teaching scripts in six distinguished teachers of internal medicine. We asked two questions: 1) Do other types of clinicians use teaching scripts? and 2) Does the level of experience affect the use or content of scripts?

METHODS: A cross-sectional study of pediatric clerkship directors attending the 1994 COMSEP meeting was performed using a specially designed questionnaire. Demographic data on level of experience and recognition of teaching excellence was obtained. Participants were given a brief clinical vignette and asked to answer two questions: What common errors will a third year medical student make? and What teaching points will you make? A coding scheme was developed, the data coded by the authors, and analyzed by faculty rank.

RESULTS: Seventy-three clerkship directors completed the questionnaire. Demographic data and data from four vignettes will be presented. The majority of responses identified a small number of errors and teaching points. No differences in responses were seen in faculty category (see table below depicting results of Asthma Vignette).

Percent of total Responses

Response to Asthma Vignette	Asst. Prof n=38	Assoc. Prof n=18	Prof. n=17
Common Errors	91%	92%	91%
Teaching Points	82%	89%	86%

CONCLUSIONS: Pediatric clerkship directors use teaching scripts which have little variability despite varying levels of experience. Faculty development programs may build on the use of scripts to aid residents and faculty in becoming better teachers.

GRANTS AVAILABLE FOR EDUCATION

Fred McCurdy was kind enough to send a list of approximately 25 different grants available from various organizations that may be

of interest to some of you. As the list was 16 pages long, I couldn't include each one along with it's detailed explanations. I took the liberty to discard three or four of the grants that were just open to individuals in a particular city, or to offspring of a particular company's employees. In most other cases I simply included a brief grant description--I did not include deadlines, amount of grant, contact person etc. with the exception of two to three major grants from large companies/ government which will probably have broad appeal to many clerkship directors. If something interests you please contact Fred McCurdy at 402-559-6569 (Fax# 402-559-5137) or Gary Freed at 404-616-4962 (FAX# 404-524-3953) for a more complete description and details of a particular grant.

1. **United Methodist Health Ministry Fund Grants for Health Care Projects.**

Provides grants for health care projects in three areas: (1) administrative and direct health care services with priority for those unable to afford health care; (2) education projects that increase public awareness of health care needs, assist people in prevention health care services, or train health care professionals and paraprofessionals; and (3) experimental programs for development of new delivery systems of health care, making health care more effective and affordable for all people.

The grant program addresses primarily needs in **Kansas.**

2. **Hillcrest Foundation Grants**

Grants are made to charitable organizations in Texas for the relief of poverty, advancement of education, and promotion of health. Funds are also awarded for construction and renovation of academic buildings and laboratories and for equipment.

3. **Pfizer Foundation Grants**

Pfizer makes donations both directly and through the foundation. In education, the company supports schools where Pfizer recruits, schools located in Pfizer-facility communities, academic departments with programs relating to business interests and business administration programs. Funded under education are programs in higher education, business/economics, and technical/ engineering education, medical education and research, and associations. Under health programs at hospitals, programs for the disabled and aged, and for substance abuse are funded.

4. **National Medical Enterprises Grants**

Within the area of education, grants go to institutions of higher education, medical education, and research for programs, staffing, and equipment. Health contributions cover a wider range of organizations including community clinics, national disease associations, and substance abuse, mental health, nutrition, and preventive health organizations.

5. **Schering-Plough Foundation Grants**

Selective support is given to higher education institutions and associations, hospitals, and cultural organizations, primarily in geographic locations in which the company has major facilities. The foundation's matching gift plan extends to accredited higher and secondary educational institutions and hospitals. Many grants help to purchase equipment for medical teaching programs or health care organizations, including computer systems; the foundation has a related interest in the establishment of health information systems and networks.

6. **Cullen Foundation Grants Program**

This private foundation awards grants to the following categories of institutions: cultural (art, science, etc.), educational (colleges, universities, elementary, secondary, and general), health (hospitals, research, handicapped, etc.), and public service.

7. **Dresser Foundation Grants**

Dresser supports educational programs of colleges, universities, and associations in business, engineering, and medicine. It also provides research and education grants for hospitals. Grants are not made to individuals nor for endowments. Scholarship grants are limited to children of employees of Dresser Industries.

8. **National Research and Demonstration Centers (NRDC) Grants**

Centers should encompass activities in fundamental research, clinical research, demonstrations

of innovations in health care delivery, and education projects for both professionals and the lay public. The center grant provides support only for the administration and integration of the research, education, and demonstration activities. These elements are funded almost entirely through separate, competitively awarded grants.

9. **MRC Medical Education Grants**

"The council recognizes that not all proposals for grant funding fall within the terms of reference of the stated programs. Therefore, the council will consider projects in the field of improvement in methods of education of health professionals." *Limited to Canada*

10. **Josiah Macy Jr. Foundation Grants**

The foundation is primarily concerned with the quality of medical education and the resultant services offered to the public by the medical professions. Medical Education grants support projects that analyze the real costs of educating a medical student and the costs for training physicians in ambulatory settings, that provide opportunities for the leaders of academic health centers to broaden their perspectives and preparation as national spokespersons on health related topics, and that explore the impact of AIDS on the preparation of physicians in training and in practice. The Minorities in Medicine High School Program is intended to improve the educational programs of the participating high schools to produce graduates well prepared for college and for careers in the medical and health professions. Also supported are Medical Conferences that address health care and medical education and promote the exchange of ideas and planning to better both of these fields.

11. **Hewlett-Packard Company and Foundation Grants**

The top priority of the company's giving program is education. The majority of giving is equipment grants to more than 100 colleges and universities supporting science, engineering, computer science, business, and medical education. Emphasis is on building creative bridges between the sciences and the humanities.

12. **Texaco Philanthropic Foundation Grants Program**

The foundation wishes to enhance the quality of life by offering support to select not-for-profit organizations. Special consideration is given to organizations working to effect, maintain, and strengthen the US free-enterprise system, to improve understanding among peoples, and to better society. The following are main categories of support: (1) Arts and culture, (2) Social enrichment, (3) Health and hospital--support is awarded to private teaching and research-oriented hospitals, medical schools, and nonprofit health research organizations. (4) Environmental protection and, (5) Education--grants are made to educational institutions which demonstrate ability to provide quality education and training opportunities with equal access to all. This area encompasses a wide range of programs and activities with major emphasis on research activities, faculty support, construction of research facilities, scholarships, and fellowships, particularly in the areas of engineering, the environment, geology, computer science, accounting, and business.

13. **General Internal Medicine and General Pediatrics Faculty Development Grants**

GRANT DESCRIPTION: Grants are intended to promote the development of skills in physicians (full time, part time, volunteer, fellows, and/or residents) who are currently teaching or who plan teaching careers in general internal medicine and/or general pediatrics training programs. As with the residency training programs in general medicine and general pediatrics, programs supported by these grants will emphasize the principles of primary care as demonstrated through continuity, ambulatory, preventive, and psychosocial aspects of the practice of medicine. Deadline dates are furnished with application instructions.
GRANT REQUIREMENTS: Accredited public or private nonprofit schools of medicine, schools of osteopathic medicine, and public or private nonprofit hospitals or other entities in the United States are eligible to apply.
PROGRAM TYPE: Faculty Development
GEOGRAPHIC LIMITATION: None

AMOUNT: $94,226-$249,539, average grant $155,475 total estimate for FY 1994 $3.638 million
CONTACT: Dr. Marco Rivo, Director, Division of Medicine, (301) 443-6190; John Westcott, Grants Manager Officer, (301) 443-6880
SPONSOR: Department of Health and Human Services 5600 Fishers Ln, Parklawn Bldg Rockville MD 20857
ORGANIZATION TYPE: Federal
CFDA REPORT/PROGRAM NO: 93.900

14. **NIH Academic/ Teacher Awards**
GRANT DESCRIPTION: This award is designed for the person who wishes to introduce or improve a curriculum that will enhance the research environment of the applicant institution as well as further the individual's own career in a specific medical or scientific discipline.
GRANT REQUIREMENTS: Awardees must hold an academic appointment at the applicant institution and commit at least half-time to developing, improving, and implementing curriculum designed to enrich the research environment. This award is made only by NCI, NHLBI, NIA, NIAID, and NCNR.
PROGRAM TYPE: Instruction/Curriculum Development
GEOGRAPHIC LIMITATION: None
CONTACT: Office of Grants Inquiries, Division of Research Grants, (301) 496-7441
SPONSOR:National Institutes of Health 5333 Westbard Ave, Westwood Bldg. Bethesda, MD 20892-4200
ORGANIZATIONAL TYPE: Federal

15. **W.M. Keck Foundation Grants Program**
The Keck Foundation concentrates on strengthening studies and programs in accredited universities, colleges and major, independent medical research institutions in the areas of earth sciences, engineering, other sciences, medical research, and medical education.
Requests from individual researchers, departments, divisions, or schools within a university must be coordinated through the president's or chancellor's office.

16. **Penn Central Corporation Contributions Program**
Grants are awarded, primarily in company operating locations, for higher education, economics, and medical education; health and welfare, including national health agencies, hospitals and hospices; and programs for youth, children, minorities, the disabled, and recreation.

17. **Robert Wood Johnson Foundation Grants**
GRANT DESCRIPTION: The foundation concentrates its grantmaking in the following areas: to assure that US citizens of all ages have access to basic health care; to improve the way services are organized and provided to people with chronic health conditions; to promote health and prevent disease by reducing harm caused by substance abuse; and to help the nation deal with the problem of rising health care costs. Applications are accepted throughout the year.

GRANT REQUIREMENTS: The foundation gives preference to applicants that have IRS 501 (c) 3 tax-exempt status and are not private foundations as defined under Section 509(a). Public agencies also will receive preference. Grants are given only in the health care field. Grants are not available for ongoing general operating expenses or existing deficits; endowment or capital costs, including construction, renovation, or equipment purchases; basic biomedical research; conferences, symposia, publications, or media projects, unless they are clearly related to the foundation's goals; research on unapproved drug therapies or devices; international programs and institutions; or direct support to individuals.
CONTACT: Edward Robbins, Proposal Manager, (609) 452-8701
SPONSOR: Robert Wood Johnson Foundation
Rt 1 and College Rd E
Princeton NJ 08543-2316

18. **Pew Charitable Trusts Grants**
These trusts support nonprofit organizations and fund specific areas of conservation, the environment, culture, education, health and human services, public policy, and religion. Grants have recently been awarded for health professional education, college and university science and math

programs, economics, hospital care research, international nutrition policy, nursing and programs to enhance the physical, social, and educational development of disadvantaged children.

COMSEP SIG

SPECIAL INTEREST GROUP FOR MEDICAL STUDENT EDUCATION

Richard Sarkin, M.D., Chair
Helen Loeser, M.D.

The SIG for Medical Student Education held a very successful meeting on May 8, 1995 during the Ambulatory Pediatric Association's Annual Meeting in San Diego. The topic for the meeting was "Facilitating Change in Medical Student Education." Fred Burg, the Vice Dean for Education at the University of Pennsylvania School of Medicine, was the keynote speaker. Fred presented a model for change called the Lewinian Force Field Analysis . This model helps to identify the driving and restraining forces for some aspect of a system that is undergoing change. SIG participants worked in small groups using this model to hypothetically explore how standardized patients could be introduced into a pediatric clerkship's summative, end of rotation evaluation. The small groups then presented summaries of their deliberations to the large group. A synopsis of the salient points from the small group discussions follows:

RESTRAINING FORCES include:

1) Children are difficult to train as standardized patients, in particular because reliable access at predetermined times is difficult, and because of ethical concerns.

2) The high cost of standardized patient programs, due to training of patients, their ongoing salary and development, the training of faculty assessors, and space requirement costs.

3) The substantial time required to run the exercise, to review both it and the student, and the time needed to be relinquished from the rest of the clerkship.

4) The inadequate value attributed to performance based exams by faculty and chairs. This may be due to perception and awareness, imperfect or absent prior experience, and lack of supporting data for effectiveness.

5) The need for leadership to get a new program up and going, which requires time and organization as well as knowledge of the method.

6) Competing priorities, both educational and those of individuals involved in medical education.

DRIVING FORCES include:

1) The immense teaching and feedback value, both formative and summative.

2) Requirements by RCC and/or USMLE is likely for this powerful evaluation tool: it is more standardized and less subjective than current methods, it evaluates skills and competencies, it taps into noncognitive areas missed by multiple choice exams.

3) The presence of an Office of Medical Education.

4) Enthusiasm for, and interest in, change on the part of the faculty, administration and students due to dissatisfaction with aspects of current situation and/or, institutional support e.g. by the chair

5) Funding may be available if this can be linked to "hot topical themes" such as competency-based teaching, measuring process and outcome.

6) Prior experience on the part of faculty or students who may be tapped as potential leaders within the department.

UNFREEZING TACTICS include:

1) Start small e.g. try an initial pilot project.

2) Involve the stakeholders, in particular likely resistors, e.g. faculty. Remember to involve students in the developmental process.

3) Share resources via cooperative efforts, for example: across departments or between schools, separating out start-up and maintenance costs.

4) Identify a strong advocate, ideally a Dean, Chair, or respected faculty member, or consider experience with this in a faculty recruitment

5) Existing OSCE already in place for the end of the Clerkships.

6) Provide data on validity and value of method.

The topic for this SIG's 1996 meeting will be "Teaching Clinical Skills." The Planning Committee consists of David Black, Donna Grigsby, Paul Kaplowitz, Steve Miller, Edward O'Rourke, Randy Rockney and Richard Sarkin. Anyone interested in medical student education is welcome to join this SIG by contacting Richard Sarkin (Children's Hospital of Buffalo, 219 Bryant Street, Buffalo, NY 14222, 716-878-7288, Rsarkin@ubmedb.buffalo.edu) or simply attending next year's SIG meeting at the 1996 APA Annual Meeting in Washington, DC.

COPE Meeting Held in May

Report to COMSEP on May, 1995 COPE Meeting

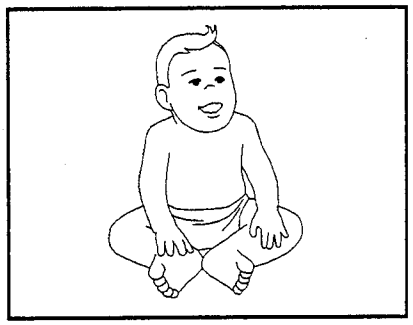
Michael Lawless
Bowman Gray School of Medicine

The annual meeting of the Council on Pediatric Education (COPE) was held at the Elk Grove, Chicago, office of the American Academy of Pediatrics on May 16-17, 1995. COMSEP was represented for the second year along with representatives from every major pediatric organization, the Editor of Pediatrics, the Editor of Pediatrics in Review, a representative of the American Academy of Pediatrics as well as academy staff members. The greatest amount of time was spent on a report entitled "Proposed Revision of the Program Requirements for Residency Education in Pediatrics". The major components of the proposed revisions were presented by Dr. Arthur Maron, Chair of the Residency Review Committee (RRC). Representatives of pediatric organizations made suggestions and expressed concerns about the proposals. The concerns were noted and will be addressed prior to a finalization of the RRC requirements.

A report from the AAP Resident Section indicated significant interest and activity in establishment of a liaison with medical student organizations toward the goal of recruitment of medical students to pediatric careers, an area also of great interest to COMSEP. Diane Kittridge, Ambulatory Pediatric Association (APA) representative, reported that the Educational Guidelines for Residency Training in General Pediatrics, a project of the APA Education Committee, is now undergoing internal and external review by committee members and numerous pediatric organizations. Fall 1995 is the target date for completion of the document. The COMSEP report was well received. Numerous favorable remarks were made regarding the General Pediatric Clerkship Curriculum presented at the AMSPDC/COMSEP meeting in San Diego in March 1995.

A major item of discussion concerned the formation of a 1995 Task Force on Pediatric Education. While many elements of the 1978 Task Force report remained timely, there were areas not addressed by that report that currently should be addressed. Due to changing circumstances other areas of the report need to be addressed again or in a different manner. Foundation funding will be sought for sponsorship of the Task Force. It is hoped that the work of this Task Force will be completed in approximately 18 months and will result in recommendations on all aspects of pediatric education.

For a variety of reasons, the American Academy of Pediatrics has decided to table recommendations for an active role in medical student recruitment or in formation of a medical student membership status. However, the Academy is finalizing a resource kit to be used by medical school Pediatric Interest Groups. Because a well-run clerkship with exposure of students to positive pediatric role models is a powerful recruitment tool, clerkship directors have a significant opportunity to enhance student interest in pediatrics. In addition, through communication and cooperation with Pediatric Interest Groups and with state AAP Chapters, clerkship directors can play an important role in enabling first and second year medical students to see pediatric practice and child advocacy early in their medical career, (Individual AAP Chapters may offer student membership even though the AAP does not have a formal student section.)



Original Paper

This paper is also being submitted to the Executive Committee of AMSPDC for approval and then hopefully will be distributed to all of the members of AMSPDC. A more generic version of this paper, "The Essential Properties of a Successful Clerkship," is now being prepared to be submitted for publication in JAMA.

THE ESSENTIAL PROPERTIES OF A SUCCESSFUL CLERKSHIP IN PEDIATRICS

Richard Sarkin, Larrie Greenberg and Andrew Wilking*

There have been many formal calls for change in medical education during this century, from Flexner's report in 1910 to the Association of American Medical Schools' 1992 paper entitled "Assessing Change in Medical Education - The Road to Implementation." Most of these calls have fallen on deaf ears, but more recently many North American medical schools, primarily as a result of external forces, have introduced changes in the way they educate their students. Some of the more common changes have been to decrease time spent in lectures; to increase the number of small group conferences; to teach cognitive skills such as problem solving; to develop self-directed learning skills; to present medical education in a more humane environment; and to introduce clinical experiences, especially in generalist settings, earlier in the curriculum.

In 1987, directors of pediatric clerkships from across North America formed a group (now called the Special Interest Group for Medical Student Education) within the Ambulatory Pediatric Association to share their experiences, to develop new programs and to discuss the evolution in medical education noted above. In 1992, the Council on Medical Student Education in Pediatrics (COMSEP) was created by the founding members of the Special Interest Group in collaboration with the Association of Medical School Department Chairmen in Pediatrics, Inc. COMSEP's goal is to foster the highest standards in medical student education in pediatrics by sharing information, developing guidelines and creating new materials pertaining to curricula, administration, instructional methodologies, evaluation procedures, and research in education.

The following paper outlines what COMSEP believes to be the critical and essential properties of a successful pediatric clerkship for medical students. The five properties that will be discussed are a receptive environment; clear content, goals and objectives; effective teachers; a committed clerkship director; and a supportive, active department chair.

ENVIRONMENT

The most important goal of the pediatric clerkship is to provide medical students with a positive educational experience that will give them a strong foundation in pediatrics regardless of their ultimate career. Towards this end, faculty, housestaff and allied health personnel must establish a learning climate which will make the students' experience an enjoyable one. A warm, initial orientation which includes logistical information can create an atmosphere in which students are made to feel welcome and expected. Subsequent mini-orientations also are appropriate as students move from one area to another within the clerkship. All members of the health care team should receive students in a collegial and friendly manner to alleviate the anxiety and uncertainty which most students experience during their first exposure to clinical pediatrics. Students should feel that they are a necessary and integral part of the team to which they are assigned and that they have the necessary resources to meet the goals and objectives of the rotation. The goals and objectives of the clerkship and the methods of evaluation should be fully discussed at the onset. Timely, behavior-specific feedback provided to students with an opportunity for remediation during the clerkship also contributes to a healthy educational environment. Faculty must be prepared to provide

support and encouragement during stressful situations that arise. In summary, faculty, residents and other health care providers can set the tone for the clerkship by stating and demonstrating that they care about students as individuals as well as learners, and that they will make good use of students' time and talents.

CONTENT, GOALS AND OBJECTIVES

Clearly defined and well-communicated content, goals and objectives will enable both teachers and students to better understand the expectations and limits of the clerkship. While clerkships will vary from school to school, an effort must be made to ensure that each clerkship provides essential knowledge, skills and attitudes of pediatrics to every student. The clerkship director and other members of the faculty should carefully determine this content, taking into account the length of the clerkship; the number of teachers and students; the size of inpatient, outpatient and community services; and the availability of departmental resources. An appropriate content presented in a range of educational experiences, with rationales suitable for adult learners, will be a base for the clerkship upon which students and faculty can rely.

An educational goal describes in general terms an expected result of an educational program. A set of clerkship goals will indicate to teachers and students the general concepts and areas thought to be of greatest importance. Goals should be written by the clerkship director and those interested in education within the clerkship and distributed to teachers and students at the beginning of the rotation.

A learning objective describes what a student will do, in terms of a specific performance, to demonstrate competency in a particular area of knowledge, skills or attitudes. Learning objectives should be written by clerkship directors and other teachers with input from students and should be provided to all teachers and students. Well-considered learning objectives will provide a number of advantages to students and teachers alike. Objectives provide guidance to teachers in planning their interactions with students. They provide guidance to students by identifying areas of particular importance in the large amount of material presented to them during the clerkship. Objectives also provide guidance to both teachers and students during the process of evaluation. Finally, objectives help to allay students' anxiety because expectations for students' learning are explicitly set forth.

The Ambulatory Pediatric Association and COMSEP have jointly developed a "General Pediatric Clerkship Curriculum and Resource Manual" to assist pediatric educators in developing content, goals and objectives for their clerkships. This curriculum is available through the administrative office of COMSEP at the American Board of Pediatrics.

TEACHERS

Faculty and housestaff play a crucial role in the success of any clerkship. They are directly responsible for teaching students. Teachers who demonstrate interest in the content and process of education and in their students have a major, positive effect on those students. Effective clinical teachers are knowledgeable, enthusiastic, fair, organized, open and available. These and other characteristics define individuals whom students consistently identify as their best teachers. Unfortunately, most instructors who are teaching medical students have experienced little or no formal training in how to effectively teach clinical medicine. Teaching on rounds and in the lecture hall, modeling professional conduct and attitudes, observing, evaluating and providing feedback to students are all skills that can be acquired. An ongoing program to improve the teaching skills of faculty and residents should be part of the activities of any department charged with teaching medical students.

CLERKSHIP DIRECTOR

The clerkship director plays many pivotal roles, and the quality of the clerkship depends on that individual's administrative and teaching abilities, creativity and

flexibility. A genuine interest in medical students and the ability to demonstrate this with ready warmth and individual concern are essential. As the person who greets and orients students at the beginning of the clerkship, the director has a unique opportunity to set the tone for the clerkship experience. With broad knowledge and perspective in pediatrics, the director is responsible for overseeing the clerkship's content, goals, learning objectives and evaluation process. The director must create, organize and maintain an infrastructure within the clerkship that will remain as a foundation long after faculty leave or change their teaching commitments. This individual must be a facilitator and role model for the faculty and the housestaff, helping them to develop their knowledge, skills and attitudes as teachers. The director must be intimately familiar with the evaluation process, maintaining its fairness and enforcing its standards.

The director should be not only a student of but an advocate for education, working within the medical school to improve undergraduate medical education as a whole. The opportunity to do research in medical education and the freedom to institute innovative programs may lead to personal growth and professional success. The director's efforts as a teacher, administrator, researcher, advocate, counselor, mentor and innovator must be rewarded through promotion in order to acknowledge the commitment required for this important position. In short, the position of clerkship director should be viewed as an asset to one's department as well as one's academic career.

DEPARTMENT CHAIR

Perhaps the most important variable in the success of the clerkship is the chair of the department of pediatrics. By being an active supporter of and a participant in the clerkship, the chair can demonstrate interest in students and their educational experience while acting as a role model for faculty and residents. The chair's perception of and approach to student education can have great influence. As an advocate for education, the chair can provide time and money for members of the faculty and housestaff to receive training in the art and science of education. This individual can further demonstrate his or her belief in the importance of education by publicly acknowledging the contributions of the faculty and housestaff to this area and by assuring that the department offers conferences dealing with education. The chair can work to promote members of the faculty in the academic hierarchy on the basis of their educational endeavors. The appointment of an individual committed to the educational experiences of medical students to the position of clerkship director is one of the chair's most important decisions in education. In addition, supporting that individual with financial and administrative resources, and providing for the director's professional growth as an educator are critical.

In summary, COMSEP believes that the above properties will form the foundation for a successful educational experience for medical students during their core clerkship in pediatrics. COMSEP's hope is that students will proclaim the pediatric clerkship to be the finest educational experience in their medical school and that, as a result of the clerkship, they will fully investigate pediatrics as a career choice.

* This paper was developed by the Council on Medical Student Education in Pediatrics' Task Force on Teaching Methods. The authors wish to thank the other members of the Task Force who contributed to this article including Janet Fischel, Fredrick McCurdy, Steve Miller, Daniel Riggs and Karen Wendelberger.

BOOK REVIEW

HOW TO LEARN AND TEACH IN MEDICAL SCHOOL: A LEARNER CENTERED APPROACH
Mark E. Quirk
205 pgs, 1994
Charles C. Thomas, Springfield, IL

Dr. Quirk is the Assistant Dean for Student Academic Achievement at the University of Massachusetts Medical School. In this capacity he provides remediation to students who, for whatever reasons, struggle with the medical school curriculum. He examines the personal and cognitive reasons for their difficulties and develops plans for their remediation. His 15 year plus experience in this area is reflected in a text that focuses on the student, the teacher, and the institution rather than the medical content of the curriculum.

The book is divided into three parts: The Learner, The Teacher, and The Medical School Environment. The Learner section is an attempt by an educator to assist the medical student in techniques of dealing with the vast amount of information that they are asked to retain, process, and use. He not only provides suggestions on how to read and listen effectively, but also on how to organize lecture notes, clinical experiences and observations to retain and recall information. The chapter on applying knowledge to gain new knowledge presents an especially helpful section on problem solving and communication skills.

Part Two focuses on The Teacher. In this section the true meaning of the title of the book becomes apparent. Quirk enables educators to move from a content-oriented approach to a learner-centered process which "focuses on preparing the student to be a competent, motivated, effective, efficient and motivated learner." If teacher/educators used this as a goal, they could change medical education and their students. Dr. Quirk's focus on the individual learning differences of students reveals this to be a time consuming, sophisticated task that requires a moderate amount of skilled observation. The chapter on identifying learning problems of the student shows this also to be a formidable, but necessary, task if a faculty member is to be a complete educator. A discussion of the inability of the student to synthesize information (clinically problem solve) is not included among the learning problems, but references to a previous chapter provide more than enough information about this potential difficulty. The remediation process for students who present with problems is less clear and in the absence of a professional educator who can confirm their problems through formal assessment and who can develop appropriate remediation, the success of this process can be less than optimal.

The final section, The Medical School Environment, describes an educational environment that promotes learner centered education. This is the shortest section and as all of us who have participated in curriculum changes in the educational environment know, revision takes the longest and may be the most difficult to implement. A "how to" chapter would be as long as the book itself, but nonetheless, the principles are clearly stated. How a medical school achieves learner-centered environment may be a task for a political scientist or at the very least a skilled politician.

All in all, How to Learn and Teach in Medical School is necessary reading for all of us that are committed to understanding the ingredients of being an effective educator. It clarifies and provides the necessary understanding of the educational process and offers the foundation of a faculty development program for the learner and the teacher alike. The text is an excellent reference and its easy readability make it a must for summer reading.

Albert P. Scheiner, M.D.
Professor of Pediatrics
Director of Pediatric Medical Student Education
University of Massachusetts Medical School
Worcester, MA

DEVELOPING THE FUTURE OF MEDICAL EDUCATION

Dr. Fred McCurdy submitted the following announcement regarding a meeting which he helped plan:

Educating Physicians for the future:
Medical Education Research Informing Practice and Policy

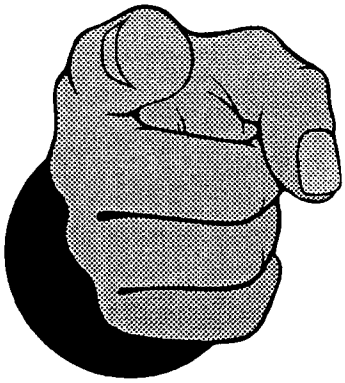
Medical educators face a plethora of challenges as they try to discern the future of medical practice to best prepare their students to function in the 21st century. Too frequently educational and public policy decisions are based on intuition, politics and convenience, rather than being informed by research. This conference will develop a prioritized list of research questions that must be answered to inform decision makers at the local and national levels as the fundamental process of medical education evolves.
To accomplish these goals, conference attendees will:

1) participate in the identification and prioritization of the fundamental skills and competencies needed by medical students, residents and practicing physicians;

2) develop innovative educational models to achieve the desired skills and competencies; and

3) identify and prioritize questions that must be answered to help medical educators and policy makers know they the are educating physicians well prepared for future practice.

Meeting to be held September 17-19, 1995 at the Dulles Hyatt outside of Washington, D.C. Those interested in attending should call the AAMC office at 202-828-0400.



IMPORTANT DATES FOR COMSEP MEMBERS

Educating Physicians For The Future
Medical Education Research Informing Practice and Policy
Dulles Hyatt
Washington, D.C.
September 17-19, 1995

AAMC Meeting
October 27-November 2, 1995
Washington, DC

COMSEP ANNUAL MEETINGS
UPCOMING DATES

1996
Tradewinds Resort
St. Petersburg Beach, Florida
March 21-24, 1996

1997
Scottsdale, Arizona
March 20-23, 1997(*Tentative Date*)

1998
Sheraton Bal Harbour
Bal Harbour, Florida
March 6-9, 1998
AMSPDC/COMSEP COMBINED MEETING

The Pediatric Educator

Winter, 1995, Vol. 2 No. 2
Albert P. Scheiner, M.D.
Editor, University of
Massachusetts Medical School
Gary Freed, D.O.
Co-Editor, Emory University
School of Medicine

"Over the last 60 years most medical schools have done little to correct the major shortcomings in the ways they educate their students, even though these deficiencies have been documented repeatedly": ACME-TRI Report - Educating Medical Students, AAMC 1992.

PRESIDENT'S MESSAGE
Larrie Greenberg, M.D.
Children's Hospital Medical
Center, Washington, DC

It's a long time in between meetings and The Pediatric Educator plays an important role in helping to communicate with the membership.

One of the most exciting things we have to look forward to is the combined AMSPDC/ COMSEP annual meeting on March 11-13, 1995, at Coronado Bay in San Diego. (See Appendix I.) Our part of the meeting will begin on Saturday afternoon and will focus on enlisting, retaining, and training faculty to help us with the educational responsibilities in our clerkships. Stuart Slavin, MD, Director of Residency Education at UCLA, will be the keynoter and will challenge and stimulate us regarding faculty development issues. We will then have small group discussions on this topic to develop game plans that we can apply in our own workplaces. On Sunday, March 12, if you've never heard Steve Abrahamson, Ph.D. speak, you're in for a treat. Along with George Miller, M.D., considered the father of medical education, Steve helped form the first office of education, research and development at Buffalo in the late 50's. He has headed the Office of Education at USC for a long time and is recognized as an educational guru. He will be the keynoter and will address diseases of the curriculum and how to cure them. The theme of this combined session will be the undergraduate curriculum initiative, chaired by Ardis Olson, M.D. (Dartmouth). Ardis will follow Steve and will emphasize the highlights of the curriculum. We will then break up into groups consisting of COMSEP members, chairs, and students from UCSD

to tackle issues we will all have to confront with this curriculum; e.g., who will teach specific objectives, in what setting, how will we be sure learning is going on, how will we evaluate the objectives, etc. Dr. Abrahamson will summarize the process he sees emerging from breakout groups. Finally, on Monday we'll have research presentations and the business meeting. For socialization, we have a great dinner planned for Saturday night and a combined banquet with AMSPDC members Sunday evening.

Recognition time - to Nan Kaufman (UC San Diego) who has been our chair to help organize the meeting. She has played a major role in recruiting facilitators for small groups and in planning our social activity Saturday night. To Ardis Olson and her project committee for their commitment, endurance and work ethic in developing the curriculum initiative mentioned above. And as always, to Jean Bartholomew, our administrative coordinator, for her always being there to prevent and put out brush fires. And lastly, to all of you who assume the different responsibilities within the organization that make us successful.

The annual Association of American Medical Colleges (AAMC) meeting was held October 29-November 4, 1994, and what struck me as a long-time participant and holder of a national office in that organization was the increasing number of COMSEP members on the program. I counted unofficially eleven of us that presented research papers, facilitated workshops, hosted innovations in medical education exhibits, and were involved in meetings. If you have not been to an annual or regional meeting, make this a priority. Call Brownie Anderson's office at the AAMC (202/828-0462) to find out what region you're in and the dates of the meetings this spring.

As I look at this group having been one of the founding members, what I see evolving is an increasing level of sophistication amongst COMSEP members in medical education, a phenomenon that has occurred over the last 5 plus years. This proactive participation of our membership is a wonderful development and I can't help but assume that this has been a result of our mutual support, sharing of ideas, and coming together with a major common thread, i.e., to make student education in our clerkships the best experience in medical school. As we continue to grow individually and as an organization, let's not forget to document our contribution to the clerkships specifically and our departments in general. We need to advocate for clinician-educator tracks in our medical schools and make certain that our chairs are not only aware of what we do, but actively supporting our educational activities. They'll be a captive audience in March and this would be a great time to get to know your own chair a little better and to schedule an appointment with him/her when you return home, building upon the

enthusiasm of the meeting.

Looking forward to seeing you in San Diego - let me hear your concerns and suggestions. Please feel free to call: (202) 884-3022, Fax: (202) 884-2399, E-Mail: (Larriech@gwuvm,gwu,edu).

ASSOCIATION OF MEDICAL SCHOOL PEDIATRIC DEPARTMENT CHAIRMEN, INC. AND COUNCIL ON MEDICAL STUDENT EDUCATION IN PEDIATRICS
ANNUAL MEETING
March 10-13, 1995
Loew's Coronado Bay Resort, San Diego, CA
Tentative Schedule
(See appendix I)

We are asking each medical school pediatric department to designate one representative to attend the meeting; i.e., either the appointed delegate or alternate delegate. Contingent on hotel and meeting space availability, we will try to accommodate more registrants if additional COMSEP members are willing to attend with a last minute notice. If the registration is received in a timely fashion, we will be able to respond quickly to those desiring to come, but would not otherwise be able.

If you have any questions contact Jean M. Bartholomew, (919) 942-1993; fax: (919) 929-9255.

COMSEP TASK FORCE ON TEACHING METHODS
Richard Sarkin, SUNY at Buffalo, Co-Chair
Karen Wendelberger, Medical College of Wisconsin, Co-Chair

The COMSEP Task Force on Teaching Methods is scheduled to meet on Monday, March 13, 1995 at the COMSEP meeting in San Diego. Several Task Force members have contributed to a "Position Paper on Medical Student Education in Pediatrics" that should be completed by the San Diego meeting. A number of other ideas were identified at the 1994 COMSEP meeting in San Antonio as possible Task Force projects, but these have remained in the planning stages. The first idea was a "Mentoring Project" where various COMSEP members or others would be identified to serve as mentors for other COMSEP members in the area of faculty development or a program to improve teaching skills. The next idea was a "How To Do a Workshop" project which might be in the form of either a document or an actual workshop to teach others how to effectively present a workshop. The last idea was a "Certification of Teaching Skills" project modeled after ACLS, ATLS or PALS courses where a course could be developed to certify teaching skills in such areas as lecturing, leading small groups or one-to-one precepting. Any member of COMSEP is welcome to attend the Task Force's upcoming meeting in San Diego as we plan our activities for this year.

COMSEP SIG
SPECIAL INTEREST GROUP FOR MEDICAL STUDENT EDUCATION
Richard Sarkin, M.D., Chair, University of Buffalo
Buffalo, NY
APA May 9 or 10, 1995
San Diego, CA

Facilitating Change in Medical Student Education Planning Committee

The topic for the 1995 APA Special Interest Group for Medical Student Education meeting in San Diego will be "Facilitating Change in Medical Student Education." The Planning Committee for this meeting consists of Gary Freed (Emory), Liz Goldman (Einstein), Harold Levine (Galveston), Helen Loeser (UCSF) and Richard Sarkin (Buffalo). The topic of change will be presented in an interactive format in both large and small groups. Successful models for change in medical student education will be explored as meeting participants are challenged to deal with obstacles to change. All those interested in medical student education in pediatrics are welcome to attend this meeting. An effort will be made to orient newcomers to both this SIG as well as the Council on Medical Student Education in Pediatrics. Anyone interested in presenting a poster at the SIG meeting should contact Rich Sarkin, Children's Hospital of Buffalo, 219 Bryant St., Buffalo, NY 14222 (Rsarkin@ubmedb.buffalo.edu).

APA workshop specifically designed for clerkship directors

If you plan to attend the 1995 APA meeting in San Diego you may be interested in this workshop (date to be announced). The COMSEP Curriculum Project staff have developed a workshop designed to provide educational consultation to clerkship directors and to introduce the new core curriculum for the clerkship. Enrollment will be limited to 16 clerkship directors to allow adequate time for discussion of general and specific issues of medical student teaching in the clerkship. Participants will be asked to complete a needs assessment and a brief questionnaire to identify problems and concerns. In addition, participants will provide the workshop leaders with copies of their current curricula--including objectives, evaluation methods, reading lists, etc. The workshop will provide participants the opportunity to assess medical student education at their own institutions and will provide guidelines for implementation of the COMSEP curriculum. Participants will discuss problems in medical student education in general as well as curricular issues pertinent to their own institutions.

How Does Your Pediatric Clerkship Curriculum Compare with the New COMSEP Core Curriculum?

Jerold C. Woodhead, M.D.
Department of Pediatrics
University of Iowa
200 Hawkins Dr., 2626 JCP
Iowa City, IA 52242-1083

The new curriculum includes detailed objectives, recommendations for teaching and guidelines for the evaluation process. It emphasizes the skills, knowledge and attitudes appropriate to the practice of General Pediatrics and is based on a firm foundation in human growth and development. The curriculum focuses on common clinical problems and

problem solving. Each participant in the workshop will receive a copy of the curriculum and the resource manual developed for the curriculum. If you are interested, please contact Jerry Woodhead: telephone: (319) 356-4964; Fax: (319) 356-4855; E-mail: jerold-woodhea@uiowa.edu

INNOVATIONS & INFORMATION

On-Line Pediatrics Clerkship Exam

Kenneth B. Williamson, Ph.D.
Robert L. Janco, M.D.
Tommy Williams
Vanderbilt Medical School, Nashville, TN

In the summer of 1992 we began discussing implementation of an on-line exam for the pediatrics clerkship. The goal was to integrate multimedia information (e.g., images) into the items and to provide a consistent presentation system with automated scoring.

The clerkship director (RL) had collected over time a set of multiple choice items that he edited and culled by using item response statistics. This yielded a pool of about 350 items with established difficulty parameters already in electronic (word processing) format.

Our first task was to create the exam interface: that is, a test item presentation shell that handled multimedia data. Drawing from our experience authoring Pathology tutorials, we designed our first system with HyperCard, a hypertext development environment for the Macintosh. (see: http://virgil.mc.vanderbilt.edu/Virgil-Lessons/VirgilDesc.html).

Our on-line exam system contains scripts that 1) perform randomized selection from the item pool, 2) present items containing multimedia data types, and 3) collect, score and tabulate student responses.

We have used this format successfully since October 1992. The clerkship director receives exam scores much more rapidly and the students prefer the computer format. Exams are much easier to prepare and administer and we have had few technical problems.

Students quickly adapt to and readily accept the on-line presentation format. They enjoy the addition of images to items, and the ability to review and change answers as they need.

Scoring is done after the test is submitted. Students have asked for immediate feedback on the test and this system has that capability, though we currently do not offer it.

Once we have additional experience with the system and become comfortable with the format and reliability, we plan to automate the gathering of item response data and to implement dynamic item selection for adaptive testing. We want not only to extend our item pool with multimedia formats, but also to acquire better information for item analysis.

However, practical exigencies forced us to turn our attention to technical issues of cross-platform access; that is, our exam system was Macintosh-based while our item editor used Windows. That factor plus the greater availability of Intel machines readily pointed us toward development alternatives.

We had already begun exploring alternatives for providing greater access to the Pathology lessons and had adopted Web browsers (e.g., Mosaic and Netscape) and Hyper Text Markup Language (HTML) as an approach. We see as advantages: 1) cross-platform, monitor-size independent display capability, 2) standardized handling of multimedia data, 3) easy network accessibility, and 4) ability to track and analyze how learners progress through lessons.

Our development goals relative to the clerkship exam were first to replicate as best as possible what we already had in HyperCard. We did this by creating an HTML forms page containing our sample of 60 test items. The test employed login (Perl) scripts that identified individuals by their student ID number and that scored the test shortly after form submission.

We conducted our first trial on December 16 and we believe it was quite successful. We encountered several server and user problems. Our server choked on the session from the sheer number of simultaneous connections made by 10 students starting the exam together. We corrected this in the next session by staggering logins. We have since increased the server's ability to handle multiple connections and plan to distribute image services over other servers so that multiple machines can serve the exam.

We also found that users became confused when using the Web browser; this was the first time most of them had seen this interface. Earlier exams employed the HyperCard interface which students had experienced in the Pathology course the year before. We now know to allow more time for students to orient to the browser interface before starting the exam.

Further development along this line involves requesting sets of items based on certain criteria and dynamically translating them to HTML for display on student browsers. Additional goals include real-time, post-test feedback to students, correcting responses and suggesting further areas for study, and development of interactive study modules which incorporate pre- and post-study evaluation strategies.

For questions, comments or additional information, contact the authors at the following Internet addresses:

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THE ALLIANCE FOR CLINICAL EDUCATION (ACE)

Fredrick A. McCurdy, M.D., Ph.D.
University of Nebraska Medical Center

The Alliance for Clinical Education (ACE) was formed in 1992. Initially, it was an umbrella organization for leadership representatives of organizations involved in clinical instruction of medical students. Under the expert guidance of Dr. O.J. Sahler, ACE has developed the following mission statement:

"The mission of the Alliance for Clinical Education (ACE) is to provide a forum for the discussion of cross-disciplinary issues relevant to the clinical instruction of medical students and the support of the involved faculty. Activities will include, but are not limited to, sharing materials, experiences, and resources; encouraging collaborative research; and working cooperatively, within the membership of ACE and in conjunction with other public and private organizations, to develop national agendas, programs, and procedures of mutual benefit with the goal of enhancing undergraduate medical education."

ACE has met during the Annual Meeting of the Association of American Medical Colleges (Fall of each year) and has been in discussion with various people within the AAMC as to how it can best interface with other groups within the AAMC. These discussions are ongoing.

ACE has sponsored plenary sessions at the past two AAMC meetings. Each plenary has dealt with interdisciplinary teaching medical students. It has also sponsored exhibits of various teaching materials available through clearing houses administered by some of the constituent member organizations of ACE. Finally, ACE has been involved in developing a manual for new clerkship directors which will soon be printed by the AAMC. In conjunction with the authorship of the clerkship director's manual, ACE has conducted two consecutive workshops for new clerkship directors at the AAMC Annual Meeting. As one can see, ACE has been a very active group almost from its inception.

At the October meeting of ACE, the leadership structure was changed. This was prompted by the announcement that Dr. Sahler would be leaving her job as Clerkship Director at Rochester to move on to become the Director of Education at the AAP. The membership of ACE voted to form a steering committee which would continue to guide the organization. The steering committee caucused and chose Dr. Fred McCurdy to chair the steering committee. Dr. McCurdy promised to try to continue the excellent record of Dr. Sahler in leading ACE, but did say that she (OJ) is a hard act to follow. Dr. McCurdy will be challenging the steering committee, over the next few months, to set a direction for ACE.

Much is changing in medicine and medical education. With change comes uncertainty. The

leadership of ACE sees this uncertainty as an opportunity to set the direction in new and innovative educational initiatives. Stay tuned for future developments.

ACE SURVEY

Last summer you probably received a survey from COMSEP asking many questions about you, your job, your clerkship, your school, etc. This survey was to be conducted as part of an ACE project to assess the state of clerkships across all of the third year in the US and Canada. Originally intended for all clerkships, the survey was only completed by the Association of Professors of Gynecology and Obstetrics (APGO), the Association of Directors of Medical Student Education in Psychiatry (ADMSEP) and COMSEP. Response rates ranged from 85% to 92% In addition, data from directors of Internal Medicine clerkships and Family Medicine clerkships was abstracted from previous surveys.

Preliminary analysis of the data reveals that the average clerkship director is a 40-50 year old male physician holding the academic rank of assistant or associate professor. He has been a faculty member for 5-10 years and a clerkship director for a little less than that. Directors of Family Medicine and Pediatric clerkships tend to have been in academic medicine as well as in their administrative position less time than their counterpart in Ob/Gyn or Psychiatry. Even though the average tenure for a director is 5-10 years, a significant number of directors have been in that position less than 5 years (range 28% for Ob/Gyn to 50% for Family Medicine). The average director works 50-55 hours per week with approximately 40% of the time devoted to teaching and administration of the clerkship. Approximately 36% of the director's time is taken up with patient care.

Clerkship directors find their position to be personally fulfilling. They express a sincere commitment to teaching and the value of teaching. They appear to consider clinical practice more valuable than research in contributing to the effectiveness of clinical teachers. Concerns and doubts are raised by directors with respect to their schools' recognition of their efforts as this pertains to the promotions process. Clerkship directors also perceive that there is a reduced amount of institutional support for their work.

This survey data is still being analyzed. The hope is that this data will lead to a publication in Academic Medicine. The people responsible for drawing together this data are Dr. Diane Magrane from APGO, Dr. Fred Sierles from ADMSEP, and Dr. Fred McCurdy from COMSEP.

Interested School Health Services:
A curriculum component that should be included in medical student and residency education.

Bradley J. Bradford, M.D.
Chair/Department of Pediatrics
Mercy Children's Medical Center
Pittsburgh, PA

Medical Student Education in Pediatrics is meticulously critical, especially as it relates to Primary Care Medicine. As the Vice President of the Pennsylvania Chapter, as well as the Residency Program Director of a Primary Care Pediatric Residency Training Program, I would like to share with you some documents that I think will be of use as you design medical student education experiences, particularly ones that will be able to emphasize school health. It is very clear that the next generation of pediatricians must be derived from the medical students cohort who understands principles of primary care and are able to work effectively in that regard.

Residency Training and Continuing Medical Education in School Health, Committee of the Section of School Health. Pediatrics. 1993;92:495-496, and Integrated School Health Services; AAP task force on integrated school health services. Pediatrics. 1994;94:400-402 are documents prepared by the Academy of Pediatrics on integrated services that I think will be of use in defining school health as well as materials on resident education in school health that may be of additional help in the medical student clerkships you direct.

ACME-TRI Report:
Educating Medical Students: Assessing Change in Medical Education: The Road to Implementation
Association of American Medical Colleges 1992
2450 N. St. N.W.
Washington, DC 20037-1126

This booklet is a guideline must for all schools contemplating medical education change. The report provides a clear outline of essential steps and objectives for change. You are unlikely to invent a better wheel: Editor.

Content includes:

I. ORGANIZATION OF THE PROGRAM & MANAGEMENT OF THE CURRICULUM

a) Centralize decision making & resource allocation for the medical students' education program;

b) Clarify institutional goals & instructional priorities.

II. FACULTY DEVELOPMENT

a) Make the teaching of medical students important;

b) Develop the skills of those responsible for clinical instruction;

c) Encourage faculty members to teach outside their disciplines.

III. EVALUATION OF STUDENTS' ACHIEVEMENT

a) Assess all major objectives;

b) Formally assess clinical skills.

IV. EDUCATIONAL STRATEGIES

a) Specify what students should learn and the skills and attitudes they should develop;

b) Foster self-directed learning and lifelong learning skills.

V. INFORMATION TRANSMISSION & MANAGEMENT

a) Decrease the use of lectures;

b) Develop information management skills.

ANNOUNCEMENTS

APS/SPR/APA
ANNUAL MEETING
May 7-11, 1995
Convention Center
San Diego, CA

SIG MEETINGS
Tuesday, May 9, 1995
9:30 a.m. - 12:30 p.m.
Wednesday, May 10, 1995
2:45 p.m. - 5:45 p.m.

APA awards in research, teaching and international health
Tuesday, May 9, 1995
5:00 p.m. - 6:30 p.m.

THE 106th ANNUAL MEETING OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES
October 27-November 2, 1995 in conjunction with

RESEARCH IN MEDICAL EDUCATION (RIME)
Call for papers - deadline May 1, 1995. For information:
RIME Conference/AAMC
2450 N. St. N.W., Suite 475
Washington, DC 20037-1126

ASSOCIATION OF MEDICAL SCHOOL PEDIATRIC DEPARTMENT CHAIRMEN, INC.
AND COUNCIL ON MEDICAL STUDENT EDUCATION IN PEDIATRICS
ANNUAL MEETING - TENTATIVE SCHEDULE
MARCH 10-13, 1995
LOEW'S CORONADO BAY RESORT, SAN DIEGO, CA

THURSDAY, MARCH 9, 1995

FRIDAY, MARCH 10, 1995

7:00-5:00	Registration-Lobby
9:00-12:00	PUPDOCC meeting
2:00-5:00	Frontiers In Science Meeting - Fellows Presentations
6:00-10:00	COMSEP Executive Committee - Dinner meeting
6:00-6:30	Pediatric Scientist Development Program and Frontiers In Science - Hospitality Hour
6:30-	Pediatric Scientist Development Program and Frontiers In Science - Dinner

SATURDAY, MARCH 11, 1995

8:00-12:00	Frontiers In Science Meeting - State-of-the-Art Speakers
8:00-12:00	PSDP Evaluation Committee - Breakfast Meeting
12:00-2:00	AMSPDC Executive Committee - Lunch Meeting
2:00-3:30	AMSPDC Executive Committee with American Board of Pediatrics Meeting**
12:30-1:30	Luncheon for PSDP Fellows and Residents
1:30-4:00	PSDP Steering/Joint Committee Meeting
2:00-5:45	COMSEP - General Session
2:00-2:15	Nan Kaufman and Larrie Greenberg: Welcome Larrie Greenberg: Overview of COMSEP and introduction of speaker
2:15-3:00	Stuart Slavin: How do we ensure quality teaching in our clerkships?
3:00-3:30	Larrie Greenberg, Moderator for Discussion Lewis First: How will this curriculum become a reality: a former clerkship director and chair's perspective Evan Charney: The right time to support student education: a Chairman's perspective Robert Nolan: The resident's role in the new curriculum: a residency training program director's perspective
3:30-3:45	Question/Answer Period
3:45-4:00	Break
4:00-5:15	Breakout Groups - approximately 7
5:15-5:45	Reports of Groups and Adjournment
7:30	COMSEP Dinner (at Peohe's)

3:00-6:00 Canadian Chairs Meeting

5:30-7:00 President's Reception

6:00 Ross Party for Residents

7:00-9:00 Canadian Chairs Dinner

SUNDAY, MARCH 12, 1995

7:00-8:00 Breakfasts for:
Southern States Chairs
Midwest Chairs
California Chairs
Pennsylvania Chairs

8:00-12:00 AMSPDC/COMSEP General Session
Frank Oski/Larrie Greenberg: Welcome

8:00-8:45 Stephen Abrahamson: Diseases of the Curriculum: Assessing the programs and managing a cure.

8:45-9:00 Questions/Answers

9:00-9:30 Ardis Olson: Introducing the new undergraduate curriculum: the need, challenges and obstacles

9:45-10:00 Susan Case, NBME: The ABC's of USMLE

10:15-10:30 Break

10:30-12:00 Breakout Groups - Approximately 8

12:00-1:30 Lunch on own

12:00-1:30 Women Chairs Lunch

1:30-3:00 Reconvene small groups

3:15-5:00 General Session - Report of Small Groups

6:00-7:00 AMSPDC Hospitality Hour

7:00-9:00 AMSPDC/COMSEP Dinner

MONDAY, MARCH 13, 1995

7:00-8:00 AMSPDC Executive Committee with American Academy of Pediatrics Executive Committee Breakfast Meeting

7:30-12:15 COMSEP General Session
Breakfast Gathering
8-9:00 Business meeting
9-10:30 Task Force Meetings in 3 Rooms
10:45-12:15 Paper Presentations-Innovations in pediatric student education
12:15 Adjournment

8:00-12:00 AMSPDC General Session