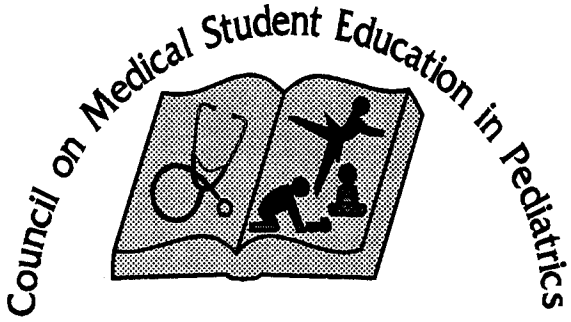
The Pediatric Educator



Volume 3 Issue 4 **Winter 1996**

Presidents Message

Ardis Olson
Dartmouth-Hitchcock Medical Center

I am surprised how difficult I find it to write a column as your president. I much prefer direct dialog with other clerkship directors. But I guess you are stuck now with my monologue. What follows are topics that I thought may be of interest.

International Connections- We have been contacted by pediatric educators in Australia and Israel. Out of this discussion AMSPDC has agreed with an affiliate member status for international members. We look forward to their participation at our meetings.

Educational Change- I have a few thoughts to share from the front-line. My perspective comes from being in the middle of experiencing major educational change at Dartmouth. For those of you whose institutions are planning to keep doing what you are doing, appreciate it. For those of you contemplating change, hang on to your hats. Briefly, we have added clinical longitudinal experiences to the first two years and are now reshuffling clerkships. My involvement is to lead the development of a 16 week primary care clerkship that combines ambulatory pediatrics, family medicine, and internal medicine with weekly shared teaching. I would like to share a few discoveries I've made. I am interested in hearing from others, whether your experiences are similar.

A few obvious, and less obvious, discoveries I've made:

1) The costs of administering a clerkship are hidden in a variety of funding streams (faculty, administration, etc.) that vary in each department with little parity between clerkships.

2) In this time of heightened clinical productivity all curriculum change is faculty time neutral. Although discouraging it is quickly apparent no one knows how much the faculty contributes to student teaching.

3) An inordinate amount of time is spent on committees setting policy about the curricular change and little time devoted to designing new ways of teaching. Of course, it is medical schools we are talking about.

4) Although I knew departments each had different approaches to medical care, it is amazing the amount of variation in student evaluation methods between departments. And everyone believes in keeping their way.

5) Always include the consumer (students) both for their fresh views and political clout.

6) All this is done without more time or money, while continuing to run the current clerkship.

Change within one's department now feels easy compared to medical school level clerkship changes. I guess being midway through the process does that to even an optimist. Sorry if all this sounds so cynical. We are continuing to slug away at reaching consensus. We even have a time line we are desperately trying to stick to. I would love to hear the positive and negative experiences you have had in implementing change in your medical schools. I would love to hear from an enlightened clerkship director with success. Send them to me by e-mail (Ardis.Olson@ Hitchock.org) or regular mail. I will be happy to share the collective wisdom later at the COMSEP meeting.

Impact of the new Residency review standards on student teaching- Have you seen the new RRC standards? As residency requirements are changing, student experiences are also likely to change. I had heard from clerkship directors finding new competition for community sites but now I am also hearing about competition for patients in the hospital clinics where residents are spending more time. What experiences are you having?

Help from the Internet- I recently discovered a new source of help about how other programs are approaching difficult issues. Our inpatient attendings are contemplating 2 week instead of 4 week rotations. I was concerned about the impact on teaching and evaluation. Through the APA-net, which is a list serve of the ambulatory pediatrics associations, I sent out my query. Within three days I had helpful information from 12 programs. If you are not an APA member find one in your department to sign on to APAnet. COMSEP has considered having a list serve. At the moment we lack an individual to lead it. If you are interested in working on this further, let me know. If you haven't logged on to the COMSEP Internet home page, do try it at http//:www.med.uci.edu/~COMSEP.

Looking forward to dialog with you at the Scottsdale meeting.

Task Force Reports

The following Reports were submitted by the Chairs of several (but not all) of the Task Forces.

Evaluation Task Force
Chair-Roger Berkow

As many of you recall at the spring COMSEP meeting in Florida the NBME shared with us the Pediatrics subject exam. At that time we reviewed the exam and ranked the questions into categories based on suitability for use as well appropriateness based on the COMSEP general pediatric curriculum. Based on this exercise the NBME felt that a more in-depth review of the exam was necessary. To accomplish this review 11 pediatric clerkship directors who had expressed interest were sent 240 questions and were asked to rank them as "A", "B", or "C", ranging from most appropriate to not appropriate. Based on this review items with "C" ratings by four or more individuals were replaced, and additional items were replaced or revised based on written comments. In total 20 items were replaced in each form of the exam and a total of 30 items were revised. These exams are undergoing final review by the USMLE Step 2 Pediatrics Committee and should be ready for use in early 1997. In addition we have maintained a dialog with NBME. This has resulted in their asking for help with question writing for both USMLE Step 2 and the Pediatric Subject Exam. If you would like to be involved please contact Susan Jacovino with the NBME at 215-590-9680, email - SJACOVINO@MAIL.NBME.ORG . We will also be playing host to members of the NBME at the spring meeting in Arizona. The final program is to be determined.

Alliance for Clinical Education
Roger Berkow

At the recent AAMC meeting in San Francisco I had the pleasure of being one of the representatives of COMSEP to a meeting of the ALLIANCE FOR CLINICAL EDUCATION (ACE). ACE is composed of representatives of clerkship directors groups from each of the major core clerkships and is intended to be a voice for clinical medical student education with the frame work of the AAMC Group on Educational Affairs . At this meeting, which is the fourth for this group, topics discussed were; The distribution of the "Handbook for Clerkship Directors." This handbook was distributed this year to clerkship directors in all disciplines, and contains a wide variety of topics which are of help especially to the new clerkship director. If you have not received this document contact whomever was the last "official" COMSEP representative from your institution. The next topic of discussion was the inclusion of the Consortium of Neurology Clerkship Directors in ACE. It was noted that Neurology was a required clerkship in greater than 50% of schools. The motion passed without problem. Additional discussion included the new computer based format for USMLE Step 1, 2 and 3 exams. The NBME will begin with Step 3 in 1998, followed by Step 1 in 1999 and Step 2 in late 1999. Early in 2000 computer based cases will be incorporated into Step 2. Other topics discussed at ACE were specific projects including Education in Women's Health, Teaching in the Ambulatory environment, Developing evidenced-based and critical thinking programs, ways to incorporate new technology, funding for medical education, and promotion and tenure in medical education.

1996 COPE MEETING

Michael R. Lawless

The annual meeting of the Council on Pediatric Education (COPE) was held July 21-22, 1996 in Elk Grove, Illinois, home of the American Academy of Pediatrics (AAP). COPE is convened by the AAP and addresses all aspects of pediatric education: medical student, residency training, specialty training and continuing education of pediatricians who have completed their training.

A major item of discussion was the newly formed Task Force which will address the future supply and training of pediatricians. The initiative is a three year project known as The Future of Pediatric Education II. In addition to developing new recommendations that will shape the type of training and continuing education needed to prepare the pediatric workforce of the future, the report will address the training of non-pediatricians, the financing of graduate medical education as well as primary care and subspecialty issues. It was repeatedly emphasized that this is a project of the entire pediatric community. The project is solidly funded and will be administered by the AAP.

The Task Force consists of sixteen members and is chaired by Jimmy L Simon. Vice-chair is Russell Chesney. Other members include Richard Behrman, Carden Johnston, Cal Sia and James Stockman, III. In addition to these six individuals the chairperson and vice-chairperson of each of the five workgroups are also members of the Task Force:

Education of the Pediatrician

Chairperson	Evan Charney
Vice-chair	Robert Johnson
Members	Tina Cheng, Diane Kittredge, Lawrence Nazarian

Financing of GME

Chairperson	Tom Boat
Vice-chair	M. Douglas Jones
Members	Harlan Gephart, Robert Adler, Lucy Osborn

Pediatric Generalists of the Future

Chairperson	Peter Rappo
Vice-chair	Laurel Leslie
Members	Renee Jenkins, Herb Abelson, Sydney Sewall

Pediatric Workforce

Chairperson	Ralph Feigin
Vice-chair	Catherine DeAngelis
Members	Lewis First, Thomas DeWitt, Robert Kelch

Pediatric Subspecialist of the Future

Chairperson	Roberta Williams
Vice-chair	Alan Gruskin
Members	Fernando Stein, Edward McCabe, Jeffrey Strickler

In order to maximize two way flow of information between the Task Force and all interested organizations and individuals, Physicians Online and the World Wide Web will be used to set up information screens and discussion forums. The following Internet Address has been established for the project: futpededII@aap.org.

The other main focus of discussion was the IL 372 Medicare regulations which pose such a chilling effect on residency education if adopted by state Medicaid programs. A resolution was adopted in opposition to these regulations which require documentation and interposition of attending physicians to the detriment of both education and financing of residency training.

REPORT OF COMSEP CURRICULUM IMPLEMENTATION ACTIVITIES

Jerry Woodhead

When the General Pediatric Clerkship *Curriculum* was presented in March, 1995, at the combined COMSEP and AMSPDC meeting, COMSEP made a commitment to encourage its wide implementation and to report on the progress of curriculum reform at the next combined meeting in 1998. Since that date, several COMSEP projects have been carried out to assess the extent to which medical schools have begun to use the new *Curriculum* and to assist medical schools to incorporate it into their programs. This report summarizes the projects and activities.

SURVEYS

Acceptance and implementation of the *Curriculum* has been addressed by surveys of COMSEP members, which indicate that it has been widely accepted in United States medical schools. Along with the accompanying *Resource Manual* for Pediatric clerkship directors, the *Curriculum* has proven to be a useful tool for reorganization and restructuring of medical student education programs in Pediatrics

The first survey in November, 1994, *before* the introduction of the *Curriculum*, indicated that while drafts had been widely circulated to the COMSEP membership during preparation of the *Curriculum*, very few schools had incorporated any of the proposed curricular changes into their programs. Only the clinical problems had been adopted by any sizable number of the programs surveyed (22/103).

In contrast, a survey carried out in March, 1996, which asked about use of specific components of the *Curriculum* found that 69.5% (57/82) of respondents used the *Curriculum* in some way. Except for the section on Child Advocacy, all of the major competency areas were taught by more than 40% of programs with a range from 41% to 63%. The clinical problems were used by 44% (35/79), approximately double the rate identified in 1994.

WORKSHOP

In order to more aggressively promote implementation of the *Curriculum*, a workshop was developed to assist medical schools to incorporate it into their medical student teaching programs. Funds remaining from the Bureau of Health Professions contract and the generous assistance of the American Academy of Pediatrics allowed us to invite teams of Pediatric educators to a workshop in Chicago, May 30 - June 2, 1996. All expenses except travel to Chicago were paid for the participants. Travel arrangements were made through the AAP, which reduced cost for attendees. Thirteen medical schools sent representatives as participants in the workshop:
Emory University,
Finch University of the Health Sciences,
Louisiana State University,
Medical College of Pennsylvania & Hahnemann University,
Rush Presbyterian-St. Lukes,
St. Louis University,
Thomas Jefferson University,
University of California-Irvine.
University of Florida,
University of Illinois-Rockford,
University of Vermont,
University of Wisconsin,
Vanderbilt University,

The medical schools represented by the facilitators included University of Iowa, Dartmouth, University of Alabama-Birmingham, University of Massachusetts, and University of Nevada. The facilitators included Jerry Woodhead, Ardis Olson, Roger Berkow, Lynn

Manfred and Jack Lazerson, each of whom had either participated in development or evaluation of the *Curriculum* or had already implemented it in a teaching program. Pam Frazier pulled everything together, made all the meeting arrangements and ensured that the workshop ran smoothly.

In brief, the workshop engaged the participants in discussions about barriers to change in medical education, ways to improve observation and evaluation of medical student clinical skills, identification of resources (financial and otherwise), the link between the clinical curriculum and the evaluation process, and assessment of educational programs. Working in small groups, participants developed learning modules based on specific segments of the *Curriculum* including advocacy, behavior, chronic illness, development, and rashes. A key feature of these learning modules was the emphasis on self-directed learning. The final activity was the development of specific action plans and time lines for implementation of the *Curriculum* in each of the medical schools represented at the workshop..

Future workshop related activities will include a survey of each participating medical school to assess the progress of implementation. Additionally, the groups working on learning modules plan to continue their work with a goal of presenting these modules to the COMSEP membership in March, 1997, at the annual meeting in Phoenix..

FUTURE ACTIVITIES

Because we have committed ourselves to a report to AMSPDC in March, 1998 about the progress of *curriculum* implementation, another survey of the entire COMSEP membership can be anticipated in 1997. The Curriculum Task force will work closely with the Evaluation Task force to develop an instrument to assess progress..
COMSEP should take pride in the progress made to date to rejuvenate medical student education in Pediatrics.

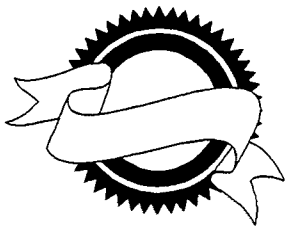
SPECIAL INTEREST GROUP FOR MEDICAL STUDENT EDUCATION

Richard Sarkin

The SIG for Medical Student Education will hold its annual meeting during the upcoming Pediatric Academic Societies' Annual Meeting in Washington, D.C., on Saturday, May 3rd from 2:00 to 5:00 p.m. The topic for the 1997 SIG meeting will be "Providing Effective Feedback to Medical Students." The goal of the meeting will be to disseminate a workshop on how to provide effective feedback so that each SIG participant will be able to present this workshop at their own institution. The feedback workshop will be fully presented at the meeting and its rationale will be explained and analyzed. Printed workshop materials will be provided.

Anyone interested in medical student education is welcome to attend the 1997 SIG meeting. There will once again be a poster session during the SIG meeting. If you have a poster or a work in progress that you would like to present as a poster at the SIG meeting, please contact Richard Sarkin (Children's Hospital of Buffalo, 219 Bryant Street, Buffalo, NY 14222, 716-878-7288, Rsarkin@ ubmedb.buffalo.edu).

Helen Loeser from the University of California San Francisco has been named the next SIG Chair. Helen will begin her three-year term as Chair after the 1997 SIG meeting.



Survey of Primary Care Day, 1996

1. I received the AAP mailing of names of Student Coordinators and Chapter Presidents along with Pediatrics 101: Facts, Figures and Assorted Intangibles and fact sheets.

_____ Yes _____ No

Comment:

2. Primary Care Day 1996 was held on October 10 (the designated day) at my medical school.

_____Yes _____No

Comment:

3. I was involved in the planning and/or implementation of Primary Care Day at my medical school.

_____ Yes _____ No

Comment:

4. The organization of Primary Care Day by a student coordinator designated by the AAMC was successful at my medical school.

_____Yes _____No

Comment:

5. The AAP Chapter in my state participated in or assisted with Primary Care Day at my medical school.

_____ Yes _____ No

Comment:

6. A successful activity or format that enhanced Pediatric presence at my medical school's Primary Care Day was:

7. Additional materials or support that would further enhance Pediatric presence at Primary Care Day include:

Please mail or fax completed questionnaire to:

Michael R. Lawless, M.D.
Department of Pediatrics
The Bowman Gray School of Medicine
of Wake Forest University
Winston-Salem, NC 27157
Fax: (910) 716-7100

Jennifer Johnson suggested that the following press release would be of interest to COMSEP members.

Washington, DC October 15, 1996

APGO Leads Interdisciplinary Women's Health Curriculum Reform Conference

In a breakthrough for women's health education, the Association of Professors of Gynecology and Obstetrics (APGO) under the leadership of Frank C. Miller, MD, President, convened an Interdisciplinary Women's Health Education Conference at the Westfield Conference Center in Chantilly, Virginia, September 27-29, 1996. Its purpose was to develop strategies to implement an interdisciplinary curriculum to increase physician competency in women's health care.

Conference participants included undergraduate medical educators from six national; educational associations- Association of Directors of Medical Student Education in Psychiatry, Association of Surgical Educators, Association of Professors of Gynecology and Obstetrics, Council on Medical Student Education in Pediatrics, Clerkship Directors in Internal Medicine, and Society for Teachers in Family Medicine- and representatives from the American Medical Association, Association of American Medical Colleges', Health Resources and Services Administration, and the National Academy on Women's Health Medical Education.

Diane Magrane, MD, APGO member and Conference Coordinator stated "By identifying core knowledge, skill and attitudes necessary for medical student education across disciplines, we can build bridges through collaboration and good will which maximize the medical students' ability, regardless of their chosen specialty, to recognize and properly care for women's health issues."

Small curricular design groups focused on subjects chosen for their common content from published women's health learning objectives: 1) adolescent pregnancy prevention; 2) breast disease detection and management; 3) cardiovascular disease prevention, diagnosis and management; 4) domestic violence prevention, detection and intervention; and 5) sexually transmitted disease prevention, diagnosis and management. The groups examined current learning objectives, outlined the barriers and promoters for change, identified the needs of the learners, and developed new ideas on what and how to teach. The result was the design of five major interdisciplinary projects with action plans for implementation.

"As a model for interdisciplinary education," stated Dee Fenner, MD, APGO Undergraduate Medical Education Committee Chair, "the conference achieved a major goal-bringing leaders from medical school disciplines together to work on educational objectives and goals to be taught throughout a four-year curriculum. The group sessions and collaborations were open, innovative, exciting and powerful."

Meeting proceedings, each group's specific objectives, and implementation time lines will be published in the December 1996 issue of *The APGO Reporter.*

Irwin Hassenfeld, MD, of the Association of Directors of Medical Student Education in Psychiatry and a conference attendee stated,

"The emphasis on groups with the goal of accomplishing something tangible with built-in follow-through, means that the Conference's impact will be felt over time. Quality medical education in women's health and other neglected topics requires a thoroughly interdisciplinary approach emphasizing collaboration of all medical specialties. This conference was an excellent model of such inter-specialty collaboration."

The conference was made possible through generous contributions from members of the APGO Medical Education Foundation Corporate Liaison Council, Berlex Laboratories, Eli Lilly and Company, Matria Healthcare, Inc., Organon, Inc., Ortho Pharmaceutical Corporation, Pharmacia and UpJohn, Searle, and Wyeth-Ayerst Laboratories.

APGO is an organization dedicated to ensuring that women receive the highest quality health care from well-educated, highly motivated physicians.

TEACHING MORE EFFICIENTLY: THE FIVE-MINUTE TEACHING SESSION

Larrie W. Greenberg, M.D.
Director, Office of Medical Education
Children's National Medical Center
Washington, D.C.

I have been fortunate to have been conducting faculty development workshops over the past 16 years, sharing ideas on how to make education more effective and fun. Over the past few years, medical schools and pediatric departments have been seeking ways to educate their faculty on how to be more effective and efficient teachers, especially considering the difficult environment in which we work. I have developed "The Five Minute Teaching Session," whose goal is to diagnose the patient and to diagnose the learner and teach him/her in a brief encounter.

The history of this workshop goes back to when I first read The One Minute Manager by Blanchard & Johnson (Berkley Publishing Group, 1982). Rich Sarkin (Buffalo) made me aware of "The One Minute Preceptor: Microskills of Clinical Teaching," by Gordon & Meyer from the Department of Family Practice in Seattle. I have taken that process and amended it to what I think is a usable, succinct and easy-to-learn technique.

The introduction to the workshop could be any warm-up exercise to get participants to think about teaching in the current environment. I then have three cases (tailored for the group I'm facilitating; e.g., I use ED cases if that's the nature of the group) in which I ask for a volunteer for each case scenario to teach either a medical student or resident. It's very helpful to have trainees there to make the simulation as realistic as possible. The trainee reads the case as if he/she has just done an H&P on that child, and the preceptor then involves the trainee in a teaching session. There are no ground rules or limitations for this session. We don't give feedback, and comments are held until after all three cases are presented. Two more volunteers do the other cases, which are presented by a student or resident.

After the cases are presented and the teaching concluded, I then get into the **Five-Minute Teaching Session**. There are eight steps I encourage teachers to use:

1. The learner's experience

The teacher needs to ask the learner what his/her experience(s) has been with similar kinds of problems. The range can be from no prior experience to seeing similar problems multiple times. This gives the teacher some perspective for this learner.

2. The case presentation

The learner presents the important historical/physical findings in the case uninterrupted and succinctly. Medical students and residents need to be taught this skill in the first two years of medical school and then this should be constantly reinforced through residency training.

3. The commitment

The learner is asked what his/her assessment of the case is. This can be framed in a differential diagnosis or from a pathophysiologic point of view. This checks the learner's ability to obtain data and integrate this information into a working diagnosis.

4. Supporting evidence

This is evidence-based medicine; i.e., the teacher is trying to determine how the learner came to the conclusion(s) he/she did. The learner should be able to justify the diagnosis from prior experience, textbook reading, and/or the recent literature.

5. The teaching point(s)

The teacher can then make a teaching point or two based on what he/she has heard from the learner. This will take into consideration the learner's prior experience and knowledge about the case.

6. Reinforcing feedback

The teacher then concentrates on behaviors that the learner has done well and provides this feedback to the learner. These points should be specific and objective.

7. Corrective feedback

The teacher focuses on how the learner can fine-tune his/her knowledge, skills, or attitudes by giving specific objective feedback on the performance.

8. Learner's objectives

The interaction concludes with the teacher having the learner identify areas concerning the case that he/she needs to perfect, such as knowledge or performance. The teacher concurs and asks the learner to approach him/her when the latter is ready to discuss/ demonstrate those learning objectives. This exercise emphasizes the learner's ultimate responsibility in meeting the objectives and in being proactive by summarizing the information for the teacher, thereby validating the process.

After finishing discussing the process, I then ask the three volunteers if they would want to amend the way they discussed their particular case with the learner. That way, each will take some-thing specific away from the workshop. For example, faculty volunteer #1 might say that she needs to find out more about the learner's experiences in the future.

In summary, I believe this is an effective, concrete, and easily applicable workshop from which all faculty can benefit. I hope it's of use to my favorite faculty, COMSEP members!

The following was submitted by Ben Siegel. Each member of COMSEP should have already received a packet of information regarding the American Academy on Physician and Patient.

American Academy on Physician and Patient

The AAPP is a national organization of physicians and other professionals committed to researching and implementing educational programs to enhance the patient/family / physician relationship. The organization began as a special interest group of the Society of General Internal Medicine, and now involves over 600 physicians with a significant number of family physicians and pediatricians (active membership 41). It is now an Academy and, in my view, is one of the most productive and creative national organizations in addressing all of the issues of improving and enhancing relationships between patients and their physician. The group has published a major Textbook: The Medical Interview Ed. Lipkin M et. al., Springer Verlag, 1995. The AAPP also publishes a newsletter which reviews recent research and current issues about the patient-physician relationship, and runs mini two and three day regional and a week long national course. I have attended two of these courses and they have been spectacular and significant in my professional experience. The week long national course will be held in Boston, June 8-12, 1997. The focus of the course is faculty development in the patient-physician relationship. I have been a member of the Academy for many years and find it a welcome place for pediatric practitioners and educators who wish to explore these issues in more depth. To find out more about the Academy, to order the book, become a member, or learn about the national course in June please contact:

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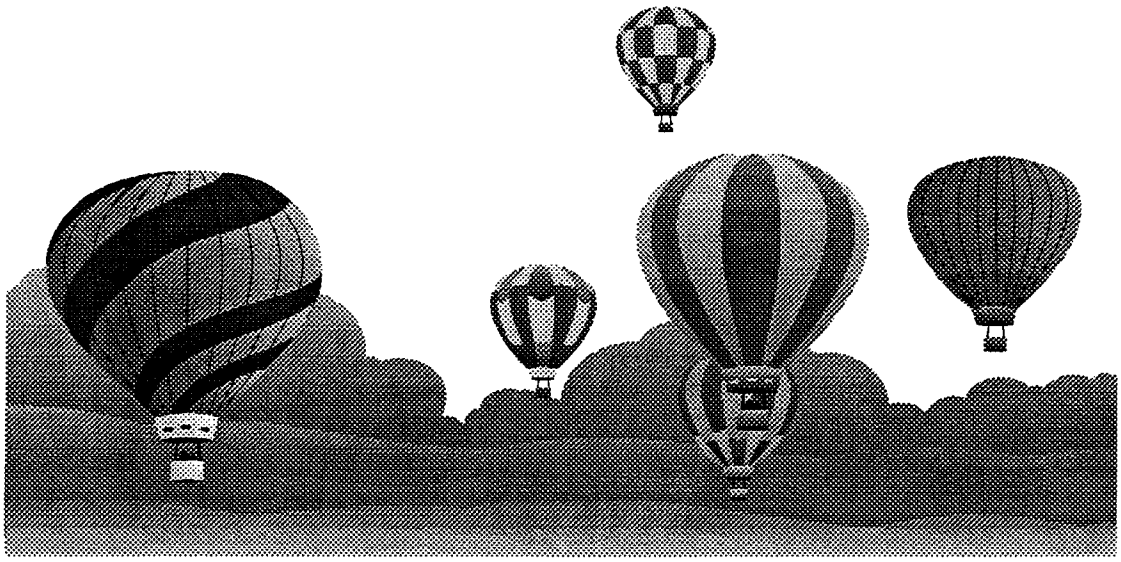
compuserve.com

Survey of Primary Care Day, 1996

Michael R. Lawless

The third annual AAMC National Primary Care Day was held October 10, 1996. On this day each year all U.S. medical schools are encouraged to have a program or activities that showcase their generalist physicians and the attractiveness of primary care careers. Student Coordinators are identified at each medical school and receive a resource kit from the AAMC. In an effort to enhance the presence of Pediatrics at National Primary Care Day, the American Academy of Pediatrics (AAP) through its Committee on Careers and Opportunities (COCO) send to each Pediatric Clerkship Director the name of the Student Coordinator at each school and the name of AAP Chapter President for each State. Each clerkship director should also have received several brochures from the AAP entitled *Pediatrics 101: Facts, Figures and Assorted Intangibles* as well as some fact sheets which could be photocopied for distribution to interested students. Following Primary Care Day in 1995 a questionnaire was distributed via the Pediatric Educator to clerkship directors in an effort to give feedback about Primary Care Day and to share good ideas for pediatric participation in the event. Please take a few minutes to complete the questionnaire regarding Primary Care Day 1996 and return it as requested. The results will be shared through a future issue of the Pediatric Educator.

See separate insert for questionnaire.



Evaluation in Education
COMSEP Annual Meeting
March 20 -23, 1997

REGISTRATION

Early registration is recommended for all participants. Please note that if you are planning to attend one of the "preconference" workshops, registration is limited to the first 20 registrants in each workshop. Registration is based on a first-come, first-served basis.

The final deadline for the "general" conference registration and preconference workshops is March 4, 1997. Make all checks payable to **MFMER** (Mayo Foundation for Medical Education and Research). Make an annotation **"for COMSEP Meeting"** on the check. Your registration fee includes two tickets to the New Directors' Mixer, continental breakfasts, refreshment breaks, Friday's luncheon, a ticket for the Rawhide Western Cookout and meeting materials. Send the meeting registration form to:

CME Registrar
Mayo Clinic Scottsdale
13400 East Shea Boulevard
Scottsdale, AZ 85259

Please include your payment for additional banquet guests to **MFMER** at the above address. Your assistance in keeping this program's expenses down is important.

Note: When calling for hotel reservations, the conference is booked under Mayo/COMSEP.

Pre-Conference Program

Thursday, March 20, 1997

COMSEP Annual Meeting Registration

Noon-4:30 p.m. Registration

PUPDOCC Meeting

1:00 p.m. Pediatric Undergraduate Program Directors of Canada Committee Meeting
2:30 p.m. Break
4:00 p.m. Adjourn

Preconference Workshops

1:00 p.m. Preconference Workshops (each limited to first 20 registrants)
2:30 p.m. Break (15 minutes)
5:15 p.m. Adjourn

Conference Program

Friday, March 21, 1997

7:30 a.m. Registration and Continental Breakfast (registrants only)
8:00 a.m. Welcome-Ardis Olson and Bruce Morgenstern
8:30 a.m. Plenary Session: "Evaluation of Students' Knowledge and Clinical Skills Performance"- Miriam Friedman Ben-David
9:10 a.m. Questions and Answers
9:30 a.m. Break
9:50 a.m. Task Force Meetings
11:45 a.m. Complimentary Luncheon
1:00 p.m. Concurrent Workshops-Session A (pre-registration is required)
3:05 p.m. Break
3:30 p.m. Concurrent Workshops-Session B
5:30 p.m. Adjourn
6:00 p.m. Baby Steps: New Directors' Mixer

Saturday, March 22, 1997

7:00-7:30 Technology Task Force
7:30 a.m. Continental Breakfast
8:00 a.m. Business Meeting
9:00 a.m. Plenary Session: "A Systematic and Systemic Approach to Curriculum Evaluation"- Miriam Friedman Ben-David
9:50 a.m. Questions and Answers
10:15 a.m. Break
10:35 a.m. Research Presentations
noon Lunch on own
1:30 p.m. Concurrent Workshops-Session C
3:30 p.m. Adjourn
5:45 p.m. Buses depart for Rawhide (pre-registration is required

Sunday, March 23, 1997

7:30 a.m. Executive Committee Meeting
Continental Breakfast for Registrants
8:00 a.m. Task Forces
10:30 a.m. Adjourn

The Pediatric Educator

Council on Medical Student Education in Pediatrics

Mailed 7/19/96

Volume 3 Issue 3 **Summer 1996**

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Editor's Note

Due to a lack of contributions this edition of the Pediatric Educator will be relatively brief.

The following Mission Statement was approved by the COMSEP Executive Committee, June 5, 1996.

The Council on Medical Student Education in Pediatrics (COMSEP) fosters excellence in undergraduate medical education in pediatrics. Functioning under the auspices of the Association of Medical School Pediatric Department Chairmen (AMSPDC), COMSEP is the official organization of educators with administrative responsibility for undergraduate medical education in pediatrics. It promotes the development, dissemination, and evaluation of curricular materials and educational resources through inter-institutional collaboration. It advocates for research in pediatric medical education. The effectiveness of members as teachers of students and faculty, and as academic leaders, administrators, and mentors, is developed and enhanced through participation in COMSEP activities.

The following are reports from various COMSEP committees.

Evaluation Task Force
Dr. Roger Berkow

The COMSEP evaluation task force met on Sunday, March 24, between 08:00 and

10:00. The task force had as their guest Douglas F. Becker, Ph.D., Senior Evaluation Officer and Director, Subject examination Program, NBME. Dr. Becker was asked to the meeting in an attempt to develop closer associations between COMSEP and NBME and to begin to voice the opinion of COMSEP that the NBME subject exam in Pediatrics, currently used by greater than 60% of U.S. medical schools, needs to reflect the content contained in the COMSEP/APA General Pediatric Clerkship Curriculum.

During the meeting, members in attendance had the opportunity to review a sample Pediatric Subject exam. The task force arbitrarily divided the exam into six parts and groups of four to six COMSEP members reviewed the questions. The questions were ranked from "A" to "E", with "A" representing a question which was appropriate for junior medical students and based on core competencies contained within the curriculum, and "E" representing questions which were totally inappropriate in the context of the junior clerkship in Pediatrics and had little to no relationship to material in the curriculum. "B" represented questions which might be appropriate if rewritten, and "C" and "D" being in between categories with the questions getting further away from the material in the curriculum. With each group reviewing 20 questions, the following distribution was noted: "A"=56,"B"=12,"C"=22, "D"=10, and "E"=20. A+B=56.6%, and D+E=25%.

This exercise was useful for the task force members as well as Dr. Becker to demonstrate that it would be entirely possible for the NBME to create an examination which is based on the concepts contained within the curriculum from their existing bank of questions. It seemed however, that Dr. Becker can not do this by himself, and asked that COMSEP members send their CV's and a letter of interest regarding the test writing committee to Dr. Don Melnick at the NBME. He also asked the leadership of COMSEP to convey to the AMPSDC leadership that the Chairs should be asked to nominate their clerkship director to the NBME writing committee. It was also suggested that a committee of COMSEP members could be developed to review (in Philadelphia) a large number of the questions within the question bank at NBME, in a similar way that we did at the COMSEP meeting. Names of interested individuals were collected. Any other interested COMSEP member can forward their name to Roger Berkow.

It was also suggested that a workshop on question writing with the NMBE might be useful for next years COMSEP meeting. [*to date, no one has gone to Phila. to work on the board questions*]

Special Interest Group For Medical Student Education
Richard Sarkin, Chair

The Special Interest Group (SIG) for Medical Student Education held its annual meeting on May 7, 1996, with approximately 80 people in attendance. The meeting focused on how we can more effectively tach physical examination skills to medical students. A plenary session dealt with different aspects of teaching clinical skills. The large group was then divided into 10 small groups to discuss our topic more informally for about an hour. A medical student from George Washington University was assigned to each of the small groups. Results of small group discussions were briefly presented to the large group and are in the process of being formally summarized. In addition, 14 posters relating to various aspects of medical education were

exhibited at our meeting.

The topic for next year's meeting will be "Providing Effective Feedback to Medical Students." Anyone interested in medical student education is welcome to join our SIG by simply attending the 1997 SIG meeting or contacting SIG Chair, Richard Sarkin -Children's Hospital of Buffalo, 219 Bryant Street, Buffalo, NY 14222, 716-878-7288, Rsarkin@ubmedb.buffalo.edu

Faculty Development Committee
Helen Loeser

One of the projects of the working group on Faculty Development is to prepare a workshop on expanded CV's, or teaching portfolios, for next year's meeting, and to include as part of that some actual Cvs to develop as teaching portfolios. We have several examples of transformed and successful CV's. We are looking for any volunteers who would like to have "consultation" and group input as part of the workshop--to actually develop such a portfolio for promotion in an academic, or clinician-educator track.

Anyone interested should contact Helen Loeser at: phone: 415-476-3471; Fax: 415-476-4009; e-mail: helen_loeser@ pedcardgateway.ucsf.edu

Announcements

Primary Care Day 1996
Michael R. Lawless, M.D.

The third AAMC National Primary Care Day will be observed October 10, 1996. While one respondent to the questionnaire about last year's event correctly observed that the year round program of encouraging "generalism" far out-weighed the emphasis of a single promotional day, Primary Care Day is one additional opportunity to spotlight Pediatrics as part of what should be a highly promoted activity. A student coordinator for National Primary Care Day is identified at each medical school. From past experience the coordinator may or may not aggressively seek out participation by the Pediatric department, therefore it may be advisable to be proactive in contacting the representative to ensure having Pediatrics represented in the Day's activities to the desired degree.

The American Academy of Pediatrics (AAP) has encouraged state AAP chapters to offer support to Primary Care Day by providing speakers, helping with displays, etc. Each medical school Pediatric department varies in their relationship with their state AAP chapter and their proximity to the resources of the chapter. If you see a way to involve chapter members or chapter resources in the activities, you should find them responsive. The AAP has also developed an attractive brochure "Pediatrics 101: Facts, Figures and Assorted Intangibles" which should be helpful as a resource for students who want to learn more about Pediatrics as a career choice. Any student may request a single free copy from AAP Publications, PO Box 927, Elk Grove, IL 6009-0927, or copies can be purchased in volume. Each pediatric clerkship director, residency director and department chair should have previously received several copies. See the survey of Primary Care Day-1995 *(next)* for additional ideas about having an effective role in this year's event.

COMSEP Questionnaire RE: Primary Care Day 1995
Michael R. Lawless, MD
Bowman Gray School of Medicine

In the last issue of The Pediatric Educator a questionnaire was included on pediatric involvement in National Primary Care Day, 1995. My thanks to the twenty-three respondents. A summary of the responses follows:

1. I received the AAP mailing of the fact sheets, Student Coordinators, Chapter Presidents.
   Yes-83% No-17%

2. I was involved in the planning and/or implementation of Primary Care Day at my medical school.
   Yes-61% No-35%
   No answer-4%
   Comments: •"AAMC wants event run by students"
   •"students did most of it"

3. The AAP Chapter in my state participated in or assisted with Primary Care Day at my school.
   Yes-30% No-65%
   No answer-4%
   Comments: •"available-used material distributed by them"
   •"could have used more practicing pediatricians"

4. A successful activity or format that enhanced Pediatric presence at my medical school's Primary Care Day was:
   •"program was planned by students"
   •"cookies and carnations for all primary care residents"
   •"booth attended by clerkship coordinator and department head"
   •"featured speaker was a pediatrician-met with students after talk"
   •"pediatric participation in panel discussion on career choice; pediatric booth with career info"
   •"panel discussion on primary care careers"
   •"allowing students to see and examine patients in the clinic and ER"
   •"booth gave out free pens"
   •"Pediatric department assisted in recruiting physicians for students to "shadow" for the day...well received by both"
   •"private practice physicians attended a round-table at lunch"
   •"used part of AAP mailing as a handout"
   •"Our program of encouraging "generalism" for 365 days a year is far preferable to a big push on a single day."
   •"speakers were featured from Primary care disciplines as well as a panel of practicing physicians from each discipline"

5. Additional materials or support that would further enhance Pediatric presence at Primary Care Day include:
   •"needed more Pediatric faculty participating"
   •"earlier notification and inventory of anticipated mailings"
   •"Pediatric 101 looks good for next year"
   •"more involvement in early planning"
   •"liked AAP materials-unaware if they were used"
   •"plan to develop a permanent display (Family Medicine had large, professionally done posters)"
   •"information about Pediatrics in more attractive packaging-such as Pediatrics 101"

The COMSEP Home Page is up at: http://www.meded.uci.edu/~comsep. It includes the core curriculum, clinical problems, and links to the resource manual (which is on the virtual hospital at the University of Iowa). More items will be added in the near future. Anyone with contributions should e-mail them to Jennifer Johnson at jjohnson@uci.edu. Or you can use the old-fashioned system and mail them to her at: UCI Medical Center, 101 City Drive South, Building 27, Orange, CA 92613-1419; phone# 714-456-6155. The Clearinghouse has continued to respond to requests for hard copies of items. But, it is hoped that in the near future we will be able to complete uploading of the "most requested" items onto the Home Page in order to function more efficiently.

The following article was contributed to The Pediatric Educator by Dr. Bruce Morgenstern from the Mayo Medical School

PEDIATRIC RESOURCES AVAILABLE TO THE CLERKSHIP DIRECTOR (AN ALPHABET SOUP)

COMSEP - The Council on Medical Student Education in Pediatrics. This is your, the clerkship directors', organization. It is a subsidiary of the **AMSPDC**, (the Association of Medical School pediatric Department Chairmen) and sponsored in part by the **ABP** (the American Board of Pediatrics). COMSEP is comprised of a group of willing and able collaborators and moral supporters. There is a COMSEP clearinghouse run by Jennifer Johnson at the University of California at Irvine. She maintains a listing of teaching resources submitted to her from Peds Clerkships around the country. She also maintains the COMSEP home page on the web at: **http://meded.com.uci.edu:80/~comsep/** (This site may be reached by using the address without the ".com", but I still needed it on 6/24/96). This home page is linked to other sites. You can access the COMSEP/APA (Ambulatory Pediatrics Association) sponsored General Pediatrics Core Curriculum at: **http://www.meded.uci.edu/~comsep/curric/comcurr/gpcurtoc.html** or at Vanderbilt's Pediatric Interactive Digital Library at: **http://www.mc.vanderbilt.edu/peds/core/** The resource manual of the curriculum can be found at: **http://indy.radiology.uiowa.edu/Providers/Societies/APA/GPCC/GPCCcontents.html** while the patient problems component is located at: **http://www.meded.uci.edu/~comsep/curric/msw6prob.html**

APA (Ambulatory Pediatrics Assn..) - has an active APA-SIG (special interest group) on Pediatrics Education, and meets annually at the APA-APS-SPR meeting, now known as the Pediatric Academic Societies. Try to attend. Look for announcements, your participation is most welcome.

AAP (American Academy of Pediatrics) has two standing committees which may impact on Pediatrics undergraduate education: **COPE** (Committee on Pediatric Education) and **COCO** (Committee on Career Opportunities). There is also an office of education at the AAP, headed by O.J. Sahler, COMSEP's first president.

AAMC (Association of American Medical Colleges)

A large and diverse group overseeing many aspects of Medical school existence. Deans belong to this group. There are subsections relating to minority affairs, basic science education, admissions, medical students, residents. Two major subsections of the AAMC include: the **GEA** (Group on Educational Affairs), which is in the process of redefining itself and it's role. You are automatically a member, but this does not necessarily mean you will receive mailings, or other information they produce. Your medical school has a Dean's Representative to the GEA, who will receive mailings. Find out who the Dean's Rep is so that you are aware of the GEA's activities. There are regional GEA's which meet annually and discuss issues related to undergraduate education. Find out who your regional GEA's officers are and get on their mailing list. **ACE** (Alliance for Clinical Education) is a relatively new group of representatives from the clerkship directors' organizations from the major clinical clerkships (Peds, IM, Surg, OB, Psych, FM). They are finding their place in the pantheon of AAMC organizations, and will probably be a major lobbying force for our efforts in the near future.

AMIA (American Medical Informatics Association). This group sponsors a number of Web sites and has a listserv e-mail group. The latter, mmatrix-L, posts a weekly update of "What's new" on the Internet, citing new Internet clinical medical resources, which are reviewed and posted with the address and a blurb about the contents of the site. Very helpful for people who realize the potential of the Internet.

The Internet (whatever that is). There are useful aspects and other parts of less clear value. What appears to be useful:

1) **e-mail**: The most courteous way to communicate about non-. urgent things with colleagues, students, buddies. Not as immediate as the telephone, not as slow and fragmented as mail or fax. Threads of "conversations" can be carried out without an interruption in your day. Also the home of e-mail users groups, often posted as **listserv**, which accumulate and spread messages to the subscribers. There are Peds specialty listservs, informatics listservs, and education listservs, even a medical education journal club.

2) **Gopher space:** One of the first and perhaps still the largest Internet "spaces." Gopher (now Turbogopher) is a software package developed at the U of MN (hence Gopher), which allows fairly easy searches for information. Not as "in" as the Web, not as nifty sites, either, but still lots of useful information (I watched the Shoemaker-Levy Comet impact Jupiter in Gopherspace).

3) **THE Web:** You need a Web browser (Netscape is free to universities and is easy) and a good connection (at least a 14,400 speed modem, although university lines are faster). Finding sites can be difficult. *Search engines* such as Yahoo or AltaVista are fast, but very frustrating. They search the text on all home pages and generate a list of "hits," or sites at which the word you're searching appears. You may generate 40,000 hits on a search you felt was reasonably specific. That's when a tool like the mmatrix-L helps. They provide addresses of sites and of indices. Web sites can be complete with text, images and sounds, and there are a number of Pediatric clerkship teaching tools already in place.

Please note that this is an incomplete list. If you have a favorite resource, please let me know!

Please complete this survey submitted by Jennifer Johnson and Fax it back to her at:
Phone: 714-456-5631 Fax: 714-456-6660

COMSEP Computer Use and Access Survey

Name:_____ Institution:_____

Title:_____ ☐ U.S. ☐ Canadian

1. Are you a COMSEP: ☐ Delegate ☐ Alternate Delegate ☐ Neither ☐ Don't know

2. Do you have a desktop computer? ☐ At work ☐ At home ☐ Both ☐ Neither

3. If you have a desktop computer, please indicate format: ☐ PC ☐ Macintosh ☐ Both

4. Which format do you ***prefer***? ☐ PC ☐ Macintosh ☐ No preference

5. Do you have ***any*** access to e-mail? ☐ At work ☐ At home ☐ Both ☐ Neither

6. Do you have ***easy*** access to e-mail? ☐ At work ☐ At home ☐Both ☐ Neither

7. If you have one, please give your preferred e-mail address:_____

8. If you have e-mail, can you attach and download files? ☐ Yes ☐ No ☐ Don't know

9. Do you have ***any*** access to the Internet/World Wide Web(WWW)?
☐ At work ☐ At home ☐ Both ☐ Neither

10. If yes, do you have ***easy*** access to the Internet/World Wide Web at ***work***? ☐ Yes ☐ No

11. Have you viewed the COMSEP home page? ☐ Yes ☐ No

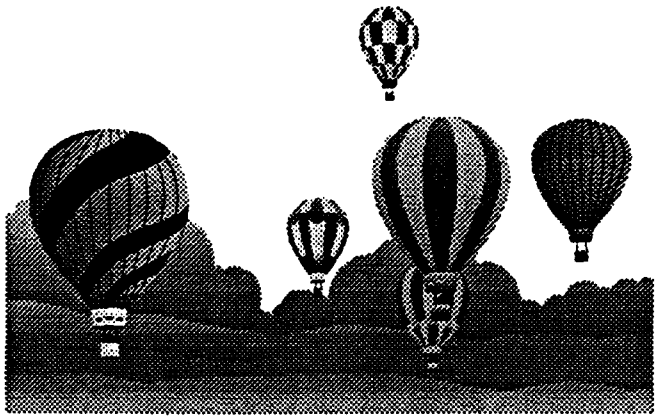
12. Do you currently utilize the Internet/WWW for medical student teaching?☐Yes ☐ No(describe)

13. Would you like to attend a workshop on computer skills at COMSEP? ☐ Yes ☐ No ☐Unsure

14. If you answered "yes" to the above question, what topics would you like covered and/or what skills would you like to develop?

15. Would you like to attend a workshop on searching the medical literature using Medline and WWW at COMSEP? ☐ Yes ☐ No ☐Unsure

16. If you answered "yes" to the above question, are there specific skills you would like to develop or topics you would like to be covered?

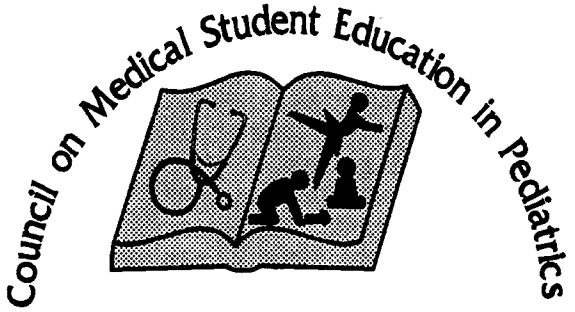


1997 Annual Meeting

Mark your calendars. The 1997 annual meeting of COMSEP will be held at the Ritz-Carlton in the Scottsdale/Phoenix area from March 20 - 23, 1997. The major theme of the meeting will be evaluation, both of students and of course offerings. Dr. Miriam Friedman Ben-David, from the ECFMG, will be giving the keynote presentations for both of the topics and will help set the stage for our usual fruitful discussions, workshops, etc. A sub-theme for the meeting will be the role of new technologies in medical education, and we hope to have computers and "technology experts" to help familiarize us with what's rapidly becoming available. We are also planning to have pre-meeting workshops on both the Educator's Portfolio and on the new science of Medical Informatics. We hope to mail out the brochures in November or early December so that you can make arrangements early.

The meeting is hosted by Bruce Morgenstern of Mayo Medical School. He is happy to entertain offers for workshops or presentations at the meeting. If you are interested, contact him at 507-284-3587 or by e-mail at: bmorgenstern@mayo.edu.

The Pediatric Educator



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Volume 3 Issue 2 **Winter 1995-96**

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A MESSAGE FROM THE PRESIDENT

Larrie W.Greenberg,M.D.
George Washington Univ.
Children's National Medical Center

President's Corner

We know when we're teaching... Do we know when students are learning?

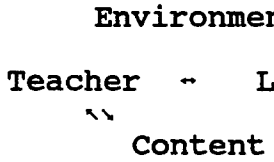
This will be my last official article for "The Pediatric Educator" as President of COMSEP,as my two year term comes to an end at our spring meeting in St. Petersburg. I leave with mixed emotions: happy to be giving up responsibilities so that I may spend more time with my wonderful and supportive wife, Joyce,and to enjoy the lives of my grown children and their spouses; and wistful that I will be handing over the reigns of a dynamic, energetic and committed organ-ization. We have matured rapidly and many of you have stepped forward to accept leadership roles: what a change from the inception of this organization when only a few of us seemed to be in the mainstream! The beauty of this organization is that my stepping down will not adversely affect COMSEP because our leadership has amazing breadth and depths.

A special thanks to the unheralded person who stands in the wings ready to offer suggestions, time, energy, empathy, humor and whatever else it takes to make a great organization function. I'm

speaking about our own Jean Bartholomew, whom many of you don't get to know because we don't meet frequently as a group. It has been my pleasure to have worked with Jean and to have spoken to her frequently about COMSEP and the behind-the-scenes activities that keep us going between annual meetings.

Hats off to the Executive Committee, Task Force leaders and others who have been innovative, creative,and ultimately successful. A special thanks to Russ Chesney, Alan Gruskin and the members of the AMSPDC Executive Committee who have been so supportive of COMSEP since our group formed.

And now for some brief comments about teaching.As I travel and observe some of the teaching that takes place in pediatric departments throughout the country, I see some trends that need to be addressed through training for medical teachers. Specifically, it seems that many of our faculty define teaching the same way their teachers did; namely, to impart information, skills or attitudes to trainees. This definition is not complete, however, without including inspiring, challenging, stimulating,and promoting problem solving and self-directed learning in our students.Perhaps most importantly,we must obsere behavioral changes in them. The model that we need to think about when we teach can be conceptualized as follows:



We should all strive to develop and maintain an interdependent relationship between the teacher, learner and content in an environment that is conducive to learning. We must work to establish this environment, in which the learner feels free to take chances and to pursue the appropriate content, skills and attitudes that we expect of him/her. Also,we have an obligation to know our learners as people and as future health care professionals, treating them as motivated and capable adults who bring varied life experiences to our clerkships. I am describing aspects of the adult learner that form the basis for how we should approach our teaching!

Our goals and objectives need to be clear to us and to our students and, as importantly, measurable and achievable in the allotted time period of their training. We also need to be accessible, especially as observers of student performance. For further characteristics of the effective teacher I refer you to David Irby's work.[2]

My last point is I think we all know when we are teaching; it's quite obvious to us, whether our teaching is planned or spontaneous.

However, we can't always be sure our students are learning. This is especially true if all we're doing is lecturing or talking at students and not allowing them to interact with us. In addition, if we don't observe the concepts we're teaching applied in the assessment and care of patients, how effective have we been? The missing piece is that often we don't have time or can't make time to observe our students in the clinical setting.

How do we accomplish this in these turbulent times of health care reform in which most of us are asked to provide more clinical care and teaching remains undervalued?

Basically, and easier said than done, we need to be more efficient in our teaching and to continue to inspire, stimulate and challenge our learners. Techniques have been developed that will enable us to spend shorter periods of time with trainees while still teaching effectively[3,4] The first steps in this process are to become leaders by learning these models ourselves, taking them back to our institutions and wworking for change there.This ripple effect (with us as the leaders) will allow our faculty to be more aware of when our students are learning.

Again, thanks for the honor of serving - see you all in St. Pete for what promises to be a most exciting meeting.

References

1.Knowles, M The Adult Learner: A Neglected Species. Houston,Gulf Publishing, 2nd Ed, 1978.

2.Irby, D. Clinical teaching and the clinical teacher J Med Educ 1988; 53: 808-815.

3.Neher, J.O. et al A five-step "micro-skills" model of clinical teaching JABFP 1992; 5:419-24.

4.Pituch, K, Harris, M, & Bogdewic, S The Brief Structured Observation Indiana U School of Medicine, 1995.

Committee Reports/ Requests

Alliance for Clinical Education ACE

Report from Fred McCurdy,MD ACE Steering Committee Chair

The ACE Executive Committee met in Washington, DC on October 29,1995 in conjunction with the AAMC meeting. The major item of business at this meeting was to approve a vision statement and goals. ACE's vision is to work in collaboration with the constituencies of the AAMC to develop innovative, integrated and cost effective models for the clinical education of medical students. The goals complement this vision. To bring this vision to fruition, ACE has been involved in an ongoing dialogue with the Group on Educational Affairs (GEA) within the AAMC. There seems to be

movement toward making ACE an integral part of the GEA.

ACE continues to work toward further collaboration in all areas of medical student education and faculty development. In this regard, ACE sponsored an Innovations in Medical Education booth at the AAMC detailing the various resource clearing houses and the information available from said clearing houses. Additionally, a presentation was made concerning the methods used to develop national curricula for Pediatrics and Internal Medicine and a New Clerkship Directors Workshop was held for the third consecutive year. Also, a collaborative research effort between Psychiatry, OB/GYN, and Pediatrics, aimed at constructing a comparative profile of clerkship directors, is nearing completion.

Finally, I informed the ACE Executice Committee that I would need to step down as Chair of the Steering Committee. Dr. Ajit Sachdeva, a surgeon at Hahneman/MCP agreed to serve as the Chair.

Special Interest Group for Medical Student Education
Richard Sarkin, Chair

Anyone interested in medical student education is welcome to attend the 1996 meeting of the SIG for Medical Student Education at the Ambulatory Pediatrics Association Annual Meeting in Washington, D.C. The topic for the 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. We will focus on how clinical skills can be more effectively taught by exploring this topic in short, large group presentations as well as small group, interactive discussions.

There will also be a poster session during the SIG meeting dealing with a variety of issues related to medical education. Anyone who might like to present a poster at our meeting should contact Richard Sarkin (Children's Hospital of Buffalo, 219 Bryant Street, Buffalo, NY 14222, 716-878-7288, Rsarkin@ubmedb.buffalo.edu)

Anyone interested in medical student education is welcome to join this SIG by contacting Richard Sarkin or by attending our SIG's annual meeting.

Original Article

The following article appeared in the Summer 1995 issue of the *AMSA Primary Care Quarterly* (Summer 1995, vol 3, No.2)

You Might Be a Pediatrician

by Michael R. Lawless, M.D.
Bowman Gray School of Medicine

Jeff Foxworthy, a Southern humorist, is famous for his book entitled You Might Be A Redneck. Throughout this work he identifies various characteristics and situations, suggesting that if they are true of you, then "you might be a redneck." With credit to Mr. Foxworthy, I propose that

if the following characteristics are true of you, then "you might be a pediatrician."

If you are considering a primary care career...

General pediatrics is the primary care of infants, children, and adolescents. Pediatricians care for patients ranging in age from newly born to college age. Each patient undergoes rapid physical, emotional and developmental changes over the span of a pediatrician's practice. Increasingly complex societal and environmental influences further challenge the pediatrician to meet the biologic and psychosocial needs of these young patients.

During a three year residency pediatricians receive training in inpatient care, normal newborn care, neonatal intensive care, behavioral science, developmental pediatrics, adolescent medicine and general ambulatory care of children, including acute emergency care. A pediatric resident also chooses electives in various subspecialty areas of pediatrics. An integral part of every pediatric residency is a weekly continuity clinic in which each resident provides care for the same panel of patients for three years.

Pediatricians in the United States number about 45,000 and represent about 20 percent of all primary care providers. Each year approximately 10 percent of American medical student graduates choose a career in pediatrics. Sixty percent of pediatric residents practice general pediatrics, and the remaining 40 percent sub-specialize.

If you enjoy both children and adults...

Many people believe that pediatrics is a great career choice for someone who loves children. It's true that children are one of the most enjoyable aspects of pediatric practice. They are mostly a pleasure to be around, and they help keep pediatricians young at heart. Children have strong recuperative powers and are remarkably resilient. In contrast to many adults, children rarely contribute to their own health problems, at least not without considerable help from adults. But pediatrics is not an escape from interaction with adults. Until they reach adolescents, children are routinely accompanied to the pediatrician's office by one or more adults. The pediatrician has significant interaction with each child's caretakers. Successful pediatricians are skillful in dealing with adults as well as with children, and take great satisfaction in their interactions with the entire family.

If you believe preventive care is important...

Historically pediatrics evolved as a medical specialty caring for children with infectious diseases such as measles, smallpox, polio, and whooping cough. With the development of vaccines, the pediatrician can focus on issues of "new morbidity," including behavioral, developmental and educational concerns.

Because injuries are a major contributor to morbidity and mortality in children and adolescents, injury prevention is important in pediatric practice. Anticipatory guidance and patient education about

household safety, auto passenger safety and environmental hazards such as lead and tobacco are important in the care of younger patients. Issues of peer pressure, substance abuse and responsible sexuality are crucial to address with older children.

Pediatrics presents a great opportunity in preventive medicine because patients have the majority of their lives yet to live. When a pediatrician looks at the patient's well-being from a long-term perspective, the potential impact on health becomes even more significant. Although preventive health results may not be dramatically played out in direct physician-patient interaction, they are no less valuable than those accomplished by more direct intervention.

If you believe children are the future of society...

Within most pediatricians is an element of advocacy for children. Children are the most vulnerable members of our society---physically, emotionally, and politically. Our future as a society is inextricably linked to the healthy physical and mental growth of our newest generation. Directly providing medical care to young patients and nurturing their healthy development is one way of fostering a healthy future. Pediatricians derive great satisfaction from seeing children restored to good health when possible, and enabling them to cope with illness when complete recovery is not possible.

Most pediatricians have a strong sense of advocacy for children in general, not just those under their direct medical care. Children don't vote. They have little political clout and no voice unless concerned adults represent their interests. Pediatricians advocate for a broad range of issues, including improved child-care provision, safety standards and vaccination laws. In addition the American Academy of Pediatrics (AAP), the national pediatrics organization, spends much of its time and resources seeking to improve the status of children, both those who receive pediatric care and those without access to medical care. The AAP's emphasis on patient advocacy is unusual among medical associations.

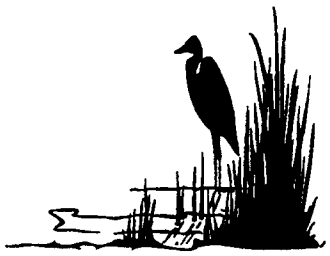
If flexibility and diversity appeal to you...

Pediatricians work in solo settings, in group and partnership practice, in health maintenance organizations, in government/public health clinics, in the military, in urban practice and in rural settings. Approximately 40 percent of pediatricians work in more than one setting.

A general pediatrician's lifestyle is flexible. Some pediatricians find it desirable to work less than full-time; approximately 13 percent of pediatricians work less than thirty-five hours a week. Shared positions in a practice provide the opportunity to enjoy pediatrics while fulfilling other personal and family responsibilities. Although pediatrics has a reputation for being on the lower end of the salary scale, the current demand for primary care physicians has brightened the financial picture. In 1993, a pediatrician's median net income (after expenses and before taxes) was $112,000, according to the AMA

Physician Marketplace Statistics. Favorable loan repayment options for physicians choosing primary care practice in undeserved areas can be beneficial to residents carrying large educational debts.

So, if you are considering a primary care career, if you enjoy both children and adults, if you value preventive care, if you believe children are our enduring legacy, and if you are flexible and like diversity, then you might be a pediatrician.



The remainder of the newsletter will deal with the upcoming COMSEP meeting to be held March 21-24, 1996 in St. Petersburg. Florida.

The 1996 Annual COMSEP Meeting is scheduled to take place from March 21-24, 1996 at the Tradewinds Resort on St. Petersburg Beach, Florida. By now, everyone should have received their application forms. Below, you will find a description of the workshops as well as the topic discussions scheduled during the conference.

Preconference workshops include an all day **OSCE Workshop** given by *Paul Gordon*, M.D., *Elizabeth Leko, Med.Ed. Specialist, and Ziad Shehab, M.D.* from the University of Arizona School of Medicine on March 21. This is a practical workshop designed to give the participants first hand experience in setting up an OSCE. The participants will be taught the basics of building an OSCE, how to train children or adolescents for standardized patients, and how to develop a blueprint for an OSCE, taking into account the needs of each participant's institution. Each participant will go home with his/her own blueprint. This particular workshop is limited to 36 participants and registration by January 15, 1996 is required. Cost is $200.

Also on March 21,there will be an afternoon **Workshop for "New" Clerkship Directors** with ≤ three years of experience and for **any other interested clerkship director** who wish to receive practical information and materials to assist them in developing and running a high quality program. This will be headed by *Fred McCurdy, M.D., and Janet Fischel, Ph.D.* This type of workshop has been presented in the past and has offered excellent practical information regarding the intricacies of the workings of a clerkship. Cost is $50.

On March 22, after the plenary session with *Lucy Osborn, M.D.* as our main speaker, we will break into groups for "topic discussions". Although some of the topics may overlap with the workshops, they should provide a different perspective and allow more participants the opportunity to acquire information. The format this year is a little different from the past. We are

fortunate to share the expertise of various clerkship directors who have developed and implemented programs which have successfully incorporated third year medical student education into the community. The main focus of these sessions is to explain how the idea for the program arose, how the program was developed, problems encountered in implementing the program, and how these problems were solved. The audience will have the opportunity to discuss and problem solve at the end of the presentations. Handouts and a bibliography of pertinent references will be distributed. Everyone will be able to attend two different topic discussions.

Below you will find a description of the Topic Discussions:

Serving the Under-Served - *David Nelson, M.D.* - Georgetown University School of Medicine,has developed a program using a mobile unit which goes directly into certain underserved areas of Washington, D.C. on a regular rotating basis in order to provide primary care to this population. Medical student education is incorporated into this setting.

How the Novice Can Develop a Faculty Development Program - *Richard Sarkin, M.D. & Steven Blatt, M.D.* - These clerkship directors from the State University of New York /Buffalo and Syracuse have teamed up to provide the basics of creating a faculty development program for the clerkship director with little experience in this area. This should prove useful in working with the academic as well as community physician.

Consistency of Student Evaluations in Multiple Community Sites - *Michael Potts, M.D.,* - University of Illinois at Chicago. Several concerns arise when you use multiple community sites for ambulatory teaching, including the logistics of such a feat, the reliability of the evaluations, and even the timely receipt of the evaluations. Dr. Potts will discuss his experience dealing with these issues and others.

Involving the Student in Day Care and School Clinics - *Beth Ellen Davis, M.D.*
At the Uniformed Services University of Health Sciences Institute, a program wwhich involves the third year students directly in a day care setting and in school-based clinics has been underway for several years. Details of both of these successful programs will be presented.

Strategies to Recruit and Retain Community Pediatric Clerkship Preceptors - *Diane Carpenter, M.D.*- From their experience of transitioning medical student education into the domain of private practice, pediatric attendings at the Medical College of Wisconsin have developed techniques to recruit and keep the private doctors interested and involved in the teaching of students.

Operation House-Call - *Ben Siegel, M.D.*- This is a program conceived at the Boston University School of Medicine. Third year students participate in actual home visits to

families with handicapped children where they have the opportunity to learn from the families themselves.

Utilizing HMOs for Education of the Pediatric Medical Student - *Linda Shaw, M.D.*- Due to the role of managed care in clinical medicine today, the Department of Pediatrics at UMDNJ Robert Wood Johnson Medical School has been incorporating HMOs as a site for third year medical student education. The students' experience will be shared with you in this topic discussion.

Outside Funding Opportunities for Student Programs - *TBA*-

Workshops will be offered Friday afternoon and repeated on Saturday afternoon. Descriptions of the workshops are as follows:

Standardized Children in Pediatric Primary Care Clinical Skills Assessment - *Lindsey Lane, M.D.*- Medical College of Pennsylvania and Hahnemann University This workshop will focus on constructing a list of desirable Pediatric Clinical Skills, developing a case and skill check lists and demonstrating training of a parent/child pair. This would be a good adjunct to the OSCE workshop.

The Brief Structured Observation - *Mitch Harris, M.D., Ken Pituch, M.D., and Steve Bogdewic, M.D.*- Indiana University School of Medicine - Riley Hospital for Children. Residents and students impress their preceptors when oral presentations are well organized and polished. However, good presentations may frequently be based upon poorly obtained (and sometimes incorrect) data. This workshop presents a technique called the Brief Structured Observation, in which the faculty preceptor observes a specific short segment of the pediatric encounter. The observation focuses on the way information is obtained. During a feedback session, the trainee identifies useful information obtained, information still needed, and the weaknesses and strengths of the information gathering techniques used. While the workshop uses videotaped encounters to train faculty, the technique requires no equipment. It uses less preceptor time than the traditional case presentation/discussion format and is useful for clinic and office-based teaching.

Managed Care and the Medical Student: Health Care Guidelines as a Tool for Education *Bruce Z. Morgenstern, M.D.*- Mayo Clinic The main focus of this workshop is how to incorporate students into what is becoming an increasingly controlled physician-patient encounter, in a way that provides a positive educational experience. There will be a didactic portion followed by a question and answer period and problem solving.

Teaching Critical Thinking- *Lynn Manfred, M.D.*- University of Massachusetts Medical Center
Critical thinking skills are the basis for medical decision making and clinical problem solving. Teaching these skills is difficult, context dependent and hard to measure. This workshop will present a method for teaching critical thinking and ways to measure its success.

How to Train Faculty Who Precept Students in the Community - *Larrie Greenberg, M.D.* -
The George Washington University Medical Center, Children's National Medical Center.
The focus of this workshop is to provide an overview with audience participation on " Why teach in the office?" What are the specific objectives that can't be taught elsewhere?
In addition, there will be an illustration with role playing on how to orient trainees to the office, how to teach a focused History & Physical and how to evaluate students in this setting.

Nuts & Bolts of a Successful Private Office Experience - *Ardis Olson, M.D.*- Dartmouth Hitchcock Medical Center
There will be a discussion of issues and materials necessary for the initiating of teaching students in private pediatric practices. These will include:

1)Activities/organization provided by the medical center

2)Practice activities before, during, and after student time in the office

Successful Workshop Planning (from soup to nuts) - *Janet E. Fischel Ph.D. & Jennifer Johnson, M.D.*- State University of NY/Stony Brook and University of Irvine
This workshop will provide participants with knowledge and practical skills for workshop planning, implementation, and evaluation. Educational methods have shifted markedly to participatory teaching, and learning through interaction, discovery and "doing". This workshop will embody those teaching and learning principles, while providing the participants a strategy for planning and carrying out workshops to enhance the skills of their trainees or colleagues in any particular subject of choice. The focus will span both details, such as seating arrangements, name tags, when to call a break, and the "big picture" issues such as effective communication, keeping it fun, identifying participant goals, engagement, getting, giving, and using feedback.

Implementation of a Community Curriculum and It's Ramifications - *Lucy Osborn, M.D.*

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On a lighter note, for those of you who are interested in bringing your families, the Tradewinds Resort offers a wide variety of activities for children. For full details ask for "Activities Department" Ext. 294 when making your hotel reservations or Ext. 57 once you have arrived

at the hotel. The following are routinely offered:

"KONK" (Kids Only No Kidding) Activities - Supervised

3-6 year olds : Thursday 9 a.m. - 12 p.m.
Friday & Saturday 6 p.m. - 9 p.m.
Cost: $15 per 3 hour daytime session
$18 per 3 hour evening session (pizza provided)
(Must be toilet trained)

7- 12 year olds: Thursday 9 a.m. - 2 p.m.
Friday & Saturday 6 p.m.- 9 p.m.
Cost: $18 per 3 hour evening session (pizza provided)
$25 per 5 hour session

Complimentary Activities (Parent Required)

2-6 year olds - 3 p.m. every day
Examples: Face painting, Finger painting, shell hunt, puppet making

7-12 year olds- Time varies (will need to check schedule)
Examples: pool games, beach games, jelly bean taste test, sand sculptures, post card designs.

Family Activities - Time varies (will need to check schedule)
Examples: Shell walk and talk; sand sculptures, audio scavenger hunt.

Teen Activities
supervised (Time varies, will need to check schedule and cost)
Examples: Bingo, Fun run on the Beach, Beach Walk, Tennis (≥16 years old)

Final Call For Abstracts
COMSEP Meeting
March 21-24, 1996

This is your last chance to submit a paper for presentation at the upcoming meeting in St. Petersberg. Articles should deal with the broad area of pediatric undergraduate education. At least one author must be either a delegate or alternate delegate to COMSEP. Delegates and alternate delegates to COMSEP may submit up to 2 abstracts each.

Instructions for submission of abstracts:

1) Limit abstracts to one typed, double-spaced 8½ x 11" page.

2) Put the title in **BOLD** capital letters at the top of the page.

3) Do not include author's names or institutions on the abstract.

4) Attach with a paper clip a 3x5 card with the title and name and institution of each author. Please list the corresponding author, full address, telephone number and FAX number on the reverse side of the card.

5) Authors wishing confirmation of receipt of their abstract should enclose a self-addressed, stamped postcard with the title of the abstract in the message portion of the card.

Abstracts Must Be Received By January 26,1996

Please mail 4 copies of the abstract, the 3 x 5 card with title, author(s), and institution(s), and the postcard (if desired) to:

Paul Kaplowitz, M.D.
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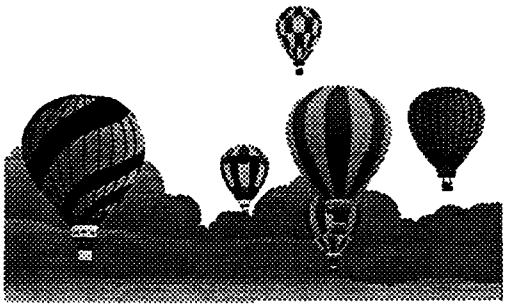
The corresponding author will be notified of the Selection Committee's decision on or about February 10, 1996.



Important Last Minute Updates:

1. There was an error in the phone number for the Tradewinds Resort in the original registration packet that went out to everyone. The correct phone number should be **1-800-237-0707.**

2. If anyone attending the conference has any special needs, dietary or otherwise, please call All Children's Hospital Conference Administration at 813-892-8834 by February 21, 1996 or make an annotation with the registration form.

3. The "Topic Discussion" entitled *Outside Funding Opportunities for Student Programs* on Friday, March 22 the session will be as follows:

   Outside Funding Opportunities for Student Programs *- Cynthia S. Selleck ARNP, DSN.* Dr. Selleck is the University of South Florida Director of Area Health Education Centers (AHEC) and will provide the participants with information on how to qualify for, apply for, and utilize AHEC as a possible source of funding for medical student programs in the underserved community.

4. Finally, the COMSEP meeting in March 1996 has had an unforseen schedule change due to a conflict of commitments by Lucy Osborn. Dr. Osborn will not be able to give her previously scheduled workshop on March 23. Instead, she will be heading one of the "Topic Discussions" on Friday morning, March 22, immediately after the plenary session. A description of her discussion is as follows:

   Title: *Focus on a Shift From Content to Skills-based Curriculum*---At the University of Utah, an experimental program at the residency level has been under way which focuses on teaching well-defined skills that need to be attained by the general pediatrician rather than on content. This skills-based teaching can be used by academic generalists, subspecialists, and community physicians alike and is especially applicable in teaching the medical student. It is felt that this may be the teaching trend of the near future. As an example, one would focus on teaching how to interpret and act upon an abnormal Infant Metabolic Screen rather than focus on teaching the details of managing the disease process which would be more in the relm of the specialist.

For those people who have not yet sent their applications in and are interested in this partcular "Topic Discussion," they should write it in under the appropriate section of the registration form and rank the order in which they are interested. For those who already sent in your application form, you may Fax any changes in Workshop or Topic Discussions to Cynthia Samra, M.D. at (813) 892-8804 no later than February 21, 1996. Remember that the Workshops and Topic Discussions will be filled on a first come, first serve basis and everyone may not receive their choice.

From Jennifer Johnson

The COMSEP Home Page is up at: http://www.meded.uci.edu/~comsep. It includes the core curriculum, clinical problems, and links to the resource manual (which is on the virtual hospital at the University of Iowa). More items will be added in the near future. Anyone with contributions should please e-mail them to Jennifer at: jjohnson@uci.edu. Or you can use the old-fashioned system and mail them to: Jennifer Johnson, UCI Medical Center, 101 City Drive South, Building 27, Orange CA 92613-1419. Phone 714-456-6155.