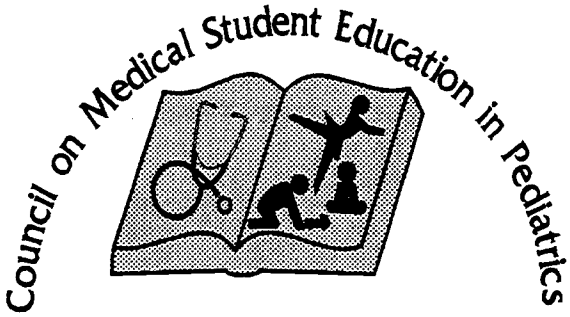
The Pediatric Educator



Volume 4 Issue 5 **Summer 1997**

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

Presidents Message

Ardis Olson
Dartmouth-Hitchcock
Medical Center

I would like to take the luxury of the presidency and the pace of summer to start this presidential column in a more reflective mood.

Every summer, as a clerkship director, is a time of change and renewal. First graduation comes, always somewhat bittersweet. I would like to keep my favorite students around but recognize that most of them will go off to new experiences. I am reminded that my work places me squarely within Erickson's developmental theories. As a pediatrician you have not focused the stages beyond adolescence, or you may know that Erickson's Mid-life developmental task is between stagnation and generativity. Generativity is the stage where one develops the ability to take the knowledge and lessons learned and impart them to the next generation. When I take that extra time and counsel a perplexed student struggling with a career choice, when I have helped students arrive at their own clinical diagnosis, I experience such the pleasure of generativity.

Of course certain of the administrative committees keep me aware of what the stagnation aspects can be.

But, honestly, I use those long stetches of graduation ritual to recall and solidify those moments into an approach for the next year. It prepares me to be available when others than students want my time. I am reminded of our key role of launching a new generation of physicians every year. During the clerkship the world of medical practice we are preparing them for seems so clear and immediate. However, by the time I am done listening to the speeches describing the future world of medicine I am not so certain if we have prepared them well. It raises basic questions that medical schools seem to answer so poorly. What skills will be needed to practice in the new cost focused medical care systems of the future?

Will theirs be a new and different type of practice where physician assistants and nurse practitioners are on the frontline with patients and physicians are consultants? What will happen to all those surgeons that we are still producing in abundance? By the time it is all done, I feel less certain indeed about what future to teach towards on the clerkship.

After passing through the self-reflection of graduation, the new third year class enters. I never cease to be amazed at how poorly the lectures of the first two years have prepared students for the independent role as learners they have in the clerkship and beyond. Between pre-clinical and clinical years there is so much difference in structure, learning content, and how competence is determined, I am amazed that students survive to become physicians. Clearly bringing in intelligent, caring people and associating them with others of the same integrity and intelligence has been our saving grace. But will the high productivity focused medical world they are entering have room for them.?

Only to the degree that I and my colleagues remember our own "cluelessness" will we have a hope of continuing to mentor these students while we are stressed. I also play another faculty role as a Clerkship Director. How do I develop an environment that includes student education on the "plate" of the residents and faculty? I feel like part task master (Where are the evaluations, no I don't want to just hear what a nice student and great team member they are), part beggar (Can you just take this extra student this time) and part cheerleader(Isn't it wonderful that students appreciate so much what you taught). Only occasionally is my role with the faculty that of visionary and motivator.

I would be a total cynic by now with such conflicting inputs and reflections, if I did not remember to listen and watch and absorb as well as give. Each year the new students come with such zeal and energy, and fourth year students depart with an exciting vision of their individual future. What a wonder to have made a difference in a few of these individuals of the the next generation. There energy is also given to me. Have a great year producing the physicians of the graduating class of 1999. After all, they will be our physicians when we retire.

The following was also submitted by Ardis and should be of interest to all COMSEP members.

If you are not aware, the U.S. MCH department has developed a pocket version of **BRIGHT FUTURES** (Guidelines for Health Supervision of Infants, Children, and Adolescents). It is an excellent guide for students on pediatric clerkships.

The Bright Futures materials are also available through the MCH web site. Each book can be purchased for $3 from the National Center for Education in Maternal and Child Health, Arlington VA (703-821-8955). Now for the good news: Pfizer pharmaceutical corp. has made them available for no cost to educators. One needs to contact your local Pfizer representative.

Committee Reports

APA SIG

Submitted by Helen Loeser

The lively May meeting of the Medical Student Education SIG was lead by Richard Sarkin, with a cameo guest appearance by Lewis First. The session was itself a successful example of how even a large and diverse group can be engaged in participatory learning. The topic was "Providing Effective Feedback to Medical Students", the experience was multimedia -

even the discussion was animated! There were also poster displays of interesting education projects underway in at least a half a dozen programs. The abstracts of these posters will be made available via the COMSEP Resource Clearinghouse/Web page, once the authors forward the materials . This feature will be continued next year, so plan/prepare to participate!

Plans for the future SIGs are already underway, and anyone interested is encouraged to join in planning and development work during the coming year. The general topic will be "Integrating the Pediatrics Curriculum across all four years of medical school" The 1998 meeting will focus in particular on the first two years (with potential future foci on: "Clerkship Design and Structure" and "Housestaff as Teachers). Members of the planning committee for the 1998 meeting are already working on the script for a videotape of what is particular to Pediatric Physical Examination skills. Other topics will include: Interface with physiology and developmental biology; Communications and the Lifecycle; Interviewing; Anticipatory guidance and prevention; Models for Pediatrics' role and participation in education.

Anyone interested in any of the above, please contact Helen Loeser:
email: helen_loeser@pedcardgateway.ucsf.edu
phone: 415-476-3471
fax: 415-476-4009

COMSEP EVALUATION TASK FORCE

Submitted by Roger Berkow

Mission Statement

The Evaluation Task force of COMSEP was created to aid COMSEP members in areas concerning the evaluation process of medical students, faculty teaching in pediatrics and the pediatric curriculum and course. The task force will aid COMSEP members by helping in the development of evaluative tools appropriate to specific needs and developing ways to aid in the assessment of core competencies of medical students (including written, oral and clinical assessment methodologies). In addition, the evaluation task force will aid other task forces in developing and implementing tools which may be needed. The task force will also serve as a clearing house through which clerkship directors with specific evaluation needs can be placed in contact with members who may be able to help them.

Current Initiatives of the COMSEP Evaluation Task Force:

OSCE Clearing House: Lindsay Lane, M.D. Jefferson Medical College, 215-955-7800. Lindsay will coordinate the assembly of pediatric OSCE, and OSCE-like stations. Please submit any available cases to her.

NBME interaction: Roger L. Berkow, M.D. (205-939-9285, Berkow@uab.edu), and Paul Kaplowit M.D. (804-828-9616, Pkaplowitz@gems.vcu.edu). Paul and Roger will coordinate the ongoing review of the NBME pediatric subject exam and to continue efforts to get this exam m in line with the COMSEP Curriculum.

COMSEP Curriculum Survey: Roger Berkow, M.D., Jerry Woodhead, M.D. an Jack Lazerson, M.D. (702-671-2217, jlazer3354@aol.com). Development of a follow-up survey on the implementation o the COMSEP Curriculum.

Grade Inflation Workshop: Roger Berkow, Karen Kaplan, M.D. (717-531-8006, kmk8@psu.edu), and David Kalwinsky (423-439-6764). This group w be helping to put together a workshop on problem of grade inflation for the next COMSEP/AMSPDC meeting.

Clinical Skills assessment w/o standardized patients/Oral Exam Scrip Gary Freed, D.O. (404-315-2801, gfreed@emory.edu) and Natesan Janakiraman M.D. (312-633-6730). This

group will collect oral exam scenarios.

Computer Based Pediatric Cases: Karen Winston, M.D. (909-824-4396). Karen will interact with the Technology task force to put together a list of pediatric case sites on the internet and to evaluate what else is out there in terms of computer based pediatric case studies.

FACULTY DEVELOPMENT TASK FORCE

Submitted by Karen Wendelberger

The FD Task Force met during the COMSEP meeting, reviewed the work of the last year and raised several important new issues. After planning at last year's sessions, there were several workshops offered during the current meeting. Jennifer Johnson and Janet Fischel once again offered a workshop on "how to" design and run workshops. Pat Kokotailo, Helen Loeser and Karen Wendelberger presented a workshop focusing on documentation of all that educator's do, what Promotion and Tenure committees look for when a Clinician-Educator is up for promotion and some ways to provide evidence for excellence in education and educational administration. Both workshops were well received and are being considered for repeat presentations at future meetings. Having looked back, we began to look at the task force's future. With the increasing emphasis on teaching in the ambulatory setting, recruiting and retaining voluntary community preceptors has become a major issue for many programs. The many members of the task force offered several suggestions, based on things that have been tried in their own programs. The challenges of providing faculty development for community preceptors was also discussed. Ideas for workshops for future meetings based on these issues were developed. Possible workshops for next year's meeting with our chairs include: 1) Community Preceptors and Teaching in the Managed Care Setting (McCurdy, Bar-on, Miller), 2) Developing workshops focused on ambulatory teaching (Fischel), 3) Effective teaching methods for adult learners (Miller, et al) and 4) Promoting the Educator/Administrator: Evidence and Documentation (Wendelberger, Kokotailo and Loeser). Anyone interested in helping please contact one of the members listed. With the expectation that many of the workshops may be repeated more than once at the meeting with our chairs, we can use lots of help and suggestions.

NATIONAL PRIMARY CARE DAY

Submitted by Mike Lawless For Donna Bundy, Project Assistant, AAP

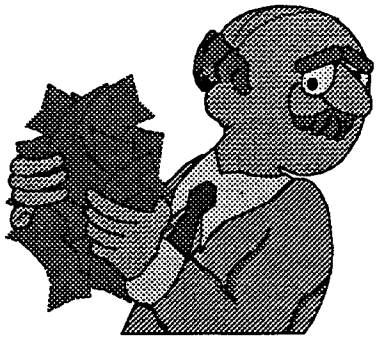
On Wednesday, October 1, 1997, the AAMC National Primary Care Day (NPCD) will take place at all US allopathic and osteopathic medical schools. The purpose of this event is to acknowledge the continued important role of generalist physicians and their contributions to medicine and society, and to raise the image and status of primary care centers. While student coordinators will take the lead in planning and implementing these activities, the American Academy of Pediatrics (AAP) encourages your participation in this event.

The AAP Committee on Pediatric Workforce (COPW) asks that you provide assistance to student coordinators as needed. The Committee on Pediatric Workforce will be sending you a packet of materials in

August that will be of assistance in this endeavor. Regam Yau, the NPCD Student Coordinator at AAMC can be reached at 202-828-0435 or you may contact him through e-mail at: ryau@aamc.org

Donna Bundy, Project Assistant American Academy of Pediatrics 800-433-9016, ext 4894 e-mail: dbundy@aap.org

MISCELLANEOUS NEWS



From Paul Kaplowitz

At the meeting in Phoenix in March, I was asked to head an new initiative on Research in Medical Education within COMSEP to help promote collaborative research projects. The survey in this issue of the Pediatric Educator is the result of a collaboration between me and Nicholas Jospe at the University of Rochester.

After we merged the surveys we each were working on, it was emailed to the 20 members of our task force, many of whom made suggestions for changing the wording of the questions and adding some questions which were incorporated into the final draft. The goal of the survey is to get a better idea of how students are reacting to their experiences in the private office environment, and how this may be affecting their likelihood of choosing pediatrics as a career. Question 17 is nearly identical to a question which appeared on the survey which was administered at 11 medical schools during the 1992-1993 year, and thus we will be able to compare the responses of the current students with a group who did pediatrics 5 years ago.

We are asking if you would like to be one of the schools participating in this study. We hope to start collecting data by the end of the first rotation of the 1997-1998 academic year, which for most schools will be August or September. Data collection will continue for one year. It is suggested that the survey be given to students when they are together at the end of the rotation, preferably at the time of their final exam. To make the analysis of the data easier, I will be setting up an Excel spreadsheet with the help of Mimi Bar-on, which will be mailed on disc with instructions to each participating clerkship director. Each of you would then need to find someone (e.g. a secretary or a student) to key in the data and mail back the disc, rather than a pile of surveys.

Some who reviewed the survey expressed concern that it requests the student's name. Nick and I feel that the type of questions asked are likely to elicit honest answers whether or not the name goes on the survey. The reason for requesting the name is that we can go back one year later and see if the people who reported a high likelihood of choosing pediatrics actually do so. If you do not feel comfortable with asking for names, you are free to delete that space and still participate. In addition, some clerkship directors expressed interest in participating but have no formal private practice preceptorship during the clerkship, though in some cases, students spend time in an office during the first 2 years or on other rotations (e.g. primary care) during the third year. Given the nature of the questions, I think it would be best if we include only clerkships where there is at least minimal private

practice exposure during the pediatric clerkship.

I look forward to having broad clerkship participation in this survey. Please email me (pkaplowitz@gems.vcu.edu) or call 804-828-9616 to let me know of your interest or to ask any questions you may have.

Evidence-Based Education Journal Club

Karen Wendelberger and the members of the Advanced Faculty Development Group Medical College of Wisconsin

Welcome to the first "meeting" of the Evidence Based Journal Club. As you know, medical educators are faced with an expanding literature base of broad-based medical education journals, specialty specific journals that include medical education articles as well as text books and Internet offerings. As we attempt to keep up with all the clinical journals needed to enhance our medical expertise, how can we possibly add the plethora of medical education articles that will keep us current as educators?

Adapting the relevance criteria developed for the evidence based medicine literature (Shaunessy, et al), a group of experienced pediatric and general internal medicine faculty have begun to select and review relevant medical education articles. The criteria for initial article selection are:

1) ***Impact:*** Does the article describe a project which significantly influences resident or student learning?
2) ***Relevance:*** Does the article focus on activities/concerns common or critical to medical education?
3) ***Potential for Change:*** If the effects described are true, will you change your behavior/activities in your medical education program?

The review process begins with reading the title and answering the three questions listed above. If all responses are "yes", then the abstract is read, the questions repeated and, if responses to the same 3 questions are still "yes" the article is assigned for review. Using this method, 14 articles were selected based on the title with 5 being final selections for review in this issue. The goal is not to provide a detailed description of each article, but to provide a general overview of the articles' focus, methodology and results while addressing the three criteria listed above.

We hope you enjoy this format. For a more complete description of the Evidence-Based Journal Club, please see *Acad Med, 1997; 72(5):464.* Please let us know what would make this column even better by e-mailing: kwendel@post.its.mcw.edu.

REVIEW 1:
Wright S, Wong A, Newill C. J Gen Intern Med 1997;12:53-56. *"The Impact of Role Models on Medical Students"*

Purpose: To assess the possible association between role models and choice of specialty for residency training.
Summary: Ninety percent of students identified one or more role models. The role model's personality (attitudes toward learners and patients, integrity, etc.), clinical competence (including enthusiasm) and teaching ability were the top three factors influencing selection. The identification of a specialty specific role model was a factor in choice of career specialty, with the strongest association being seen in Pediatrics (odds ratio 12.9, CI 1.6-267).
Evaluation: This study does not impact on learning specifically, but is an important and common issue in medical education. A role

Survey on Pediatric Office Preceptorships

Name _____ **Date** _____

1) The amount of time I spent in a pediatrician's office prior to starting pediatrics (includes both preclinical and M-III experience) was approximately ____days

2) The amount of time I spent in a pediatrics office during the pediatric clerkship was ____ days

3) Before starting my pediatrics clerkship, my feeling about pediatrics as a career choice for me was: (circle one) 1=strongly positive 2=positive 3=neutral 4=negative 5=strongly negative

4) By the end of my pediatric clerkship, my feeling about pediatrics as career choice for me was: (circle one) 1=strongly positive 2=positive 3=neutral 4=negative 5=strongly negative

Please rate the following statements on the private office experience during the pediatrics clerkship using the following scale:

1=strongly agree, 2=agree, 3=neutral, 4=disagree, 5=strongly disagree

5) The preceptorship was an excellent learning experience ____
6) I was exposed to a wide spectrum of diseases of children ____
7) I spent an appropriate amount of time seeing well-child visits and mild disease ____
8) I examined patients on my own much of the time and presented them to my preceptor ____
9) The time I spent observing my preceptor seeing patients was valuable ____
10) My preceptor was a good role model, particularly when talking to and educating patients and parents ____
11) I learned how to be efficient in doing H&Ps in a fast-paced setting ____
12) The doctor(s) in the practice usually had enough time to teach me ____
13) I learned a lot about the functioning of a pediatric practice ____
14) I learned about the cost of medical care and different types of insurance, including managed care ____
15) I was able to observe the effects of societal issues on child health ____
16) I learned that pediatricians have a variety of roles in promoting child health, including being advocates for children and working in the community ____

17) Please rate as to how they influenced your opinion of the field of pediatrics:
1=very positive; 2=positive; 3=no influence; 4=negative; 5=very negative

a) your ward attending ____
b) your ward resident(s) ____
c) patients you worked with on the wards ____
d) attendings in the ER and outpatient clinics ____
e) your private practice preceptor(s) ____
f) your interactions with the pediatric interest group ____
(if no such group at your institution, enter N/A)

Any comments you would like to share (use reverse side):

for change can be seen in assisting faculty development efforts focused on mentoring skills. This interesting and well designed study provides good information but will probably not change people's practices.

REVIEW 2:

Kroboth, Hanusa, Parker. J Gen Intern Med 1996;11:551-553. "Didactic Value of the Clinical Evaluation Exercise"

Purpose: To document the amount and type of knowledge gained by interns from participating in a clinical evaluation exercise (CEX).
Summary: Sixty seven interns, observed performing an H&P were provided direct feedback using an evaluator-completed form and gave feedback using additional forms. An average of 13.5 teaching points (identified as observed errors) were identified in each observation. Interns recalled 46% of the teaching points listed on the feedback forms. In the 23 CEXs observed by two evaluators, interrater reliability on teaching points was 18%. Positive feedback rarely occurred.
Evaluation: This article attempts to address an important gap in medical education: the lack of feedback on basic skills based on direct observation. It is extremely common and critical in light of the push for competence based evaluation. A well designed study could assist in developing improved feedback methods in many settings. This paper, however, suffers from a few fatal flaws, including omission of 25% of forms in the analysis, failure to describe how the feedback forms were developed or whether validity and reliability were tested. In addition, multiple comparisons without an obvious hypothesis dilute the power of the analysis of subgroups.

REVIEW 3:

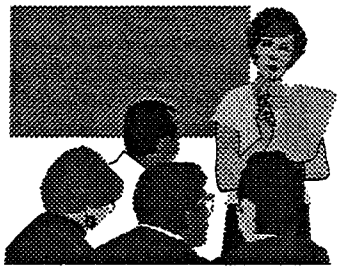
Lichstein PR, Young G. J Gen Intern Med 1996;11:406-9. "My Most Meaningful Patient: Reflective Learning on a General Medicine Service"
Purpose: To determine the usefulness of reporting on "My most meaningful patient" in facilitating reflective practice and learning for students, residents and attendings on a general inpatient medicine service.
Summary: Analysis of learners' written reports on their most meaningful patients reveal six basic themes with an average of 2.09 themes/report. Biomedical (pathophysiology, interesting findings, etc.) and communication (trust, giving bad news, etc.) themes were the most common followed by psychosocial (impact of illness on other aspects of life), physician roles/impact, and learner's feelings. This exercise was memorable for all involved and attendings, particularly, were somewhat surprised by the experiences of their team.
Evaluation: The value of reflection and discussion of "non-medical" issues has been gaining increasing emphasis as we travel the road of managed health care and the importance of patient satisfaction. This article describes an easy method of delving into these issues on an individual basis. The art of reflection as a practitioner is also critical to the professional behavior of those we teach. Implementing the method, even without the coding, would be easy and may aid us in addressing these often difficult-to-assess issues in a non-threatening yet enlightening manner.

REVIEW 4:

Gruppen LD. Acad Med 1997;72:117-120. *"Implications of Cognitive Research for Ambulatory Care Education"*

Purpose: To describe and discuss the impact of four major concepts in the

cognitive theory of learning, especially as they apply to medical education in the ambulatory setting.
Summary: This article describes four concepts of cognitive theory including: 1) the importance of context, 2) the concept of transferable knowledge, 3) balancing depth and breadth of knowledge and 4) a priori knowledge use in problem solving. The implications of each concept as it applies to medical education in the ambulatory setting is reviewed. These implications include: teaching in a context as close to the expected context of use, addressing the frequency of experiences as it affects transferability of skills and depth of knowledge, and the importance of balancing depth and breadth of experiences so that the student's ability to integrate and apply previous knowledge is optimized. The "teacher's" need to diagnose the impact of this previous knowledge suggests an area of skill development that would benefit the faculty.
Evaluation: Incorporating concepts from this timely review of learning theory and its application to ambulatory education, could have significant impact on student and resident education. The increasing specialty board emphasis on learning in the ambulatory setting makes this a common and critical issue. This is a well written article whose principles can be used to guide programmatic change in response to learner needs and external requirements. Instead of just "putting the learner in the ambulatory environment" cognitive theory provides food for thought in the design of new experiences.



1998 Annual Meeting
March 6-9
Sheraton Bal Harbour
Ft. Lauderdale, FL

This years conference is the combined AMSPDC/ COMSEP meeting. An integral part of this meeting is the organization and implementation of workshops that are attended by both clerkship directors and department chairs. The question needs to be answered regarding the number of workshops held at any one time as this will ultimately deciding the size of the workshop. A clerkship director and chair will run each of the workshops. Anticipating a total of 200 clerkship directors and chairs attending, with eight workshops taking place, there would be approximately 25 in each workshop; with ten workshops, there would be 20 in each workshop. Advance signup for workshops will be required. The workshop topics being considered are:

1. Different models for determining the cost of education
2. Determining the skills of the clerkship director
3. Teaching solutions in a time of declining inpatient census
4. Matching program goals and objectives to evaluation methods
5. Clinical pediatric experiences in the first two years
6. Program evaluation—how to develop a non-crisis approach
7. Teaching in the community in the presence of managed care
8. Integration of basic sciences with clinical medicine
9. Promotion of the educator-documentation and process
10. Distance learning and new technologies-what can be used for teaching
11. Internet—friend or foe—what can be used for teaching

12. Providing feedback

The teaching task force will most likely do three of the workshops (promotion of the educator, teaching in the community, and providing feedback); the technology task force will do the distance learning workshop; Karem Wendelberg volunteered to be involved with the workshop on integrating basic and clinical sciences in the curriculum. Ardis is looking for volunteers to help chair these sessions. If you have a particular expertise or interest in any of the proposed workshops please contact her. In particular, she is looking for help with the workshop: Matching program goals and objectives to evaluation methods. However, anyone interested in *any* of the workshops should contact Ardis at Ardis.L.Olson@Hitchcock.ORG or call her at 603-650-7798; fax 603-650-5458.

The following "Future of Pediatrics" was sent to me by Jean Bartholomew. To learn more or for general information contact:
Mary Ruth Black: Health Policy Analyst
Future of Ped. Education II
800/433-9016,ext 7914
mback@aap.org

THE FUTURE OF PEDIATRIC EDUCATION PROGRESS REPORT:

FEBRUARY 1997

Task Force on the Future of Pediatric Education II
Members:
Jimmy L. Simon, MD, Chairperson
Russell Chesney, MD, Vice Chairperson

Richard Behrman, MD
Thomas Boat, MD
Evan Charney, MD
Catherine DeAngelis, MD
Ralph Feigin, MD
Alan Gruskin, MD
Robert L. Johnson, MD
Carden Johnston, MD
M. Douglas Jones, Jr, MD
Laurel Leslie, MD
Peter Rappo, MD
Cal Sia, MD
James Stockman III, MD
Roberta Williams, MD

The Task Force on the Future of Pediatric Education II (FOPE II) held its first meeting on June 22-23, 1996, in Chicago. Considerable discussion centered on the identified goals and anticipated outcomes of the Project. The Task Force looked to the meeting minutes and the final report of the 1976-78 Task Force on the Future of Pediatric Education and considered globally numerous issues that will shape its deliberations. It was acknowledged that some issues addressed in the 1978 Report had remained constant, while there have been other recent developments in areas such as health policy and health care financing. The Task Force identified the expectations for the report that will be generated at the end of the Project. The next Task Force meeting will be held on May 5, 1997, in Washington, DC.

The Task Force will oversee five topic-specific Workgroups that will provide an in-depth analysis of key issues. All five of the Workgroups have held meetings. Following are brief updates on the activities of all of the Workgroups:

Education of the Pediatrician Workgroup
Members:
Evan Charney, MD, Chairperson
Robert L. Johnson, MD, Vice- Chairperson
Tina Cheng, MD, MPH
Diane Kittredge, MD
Lawrence Nazarian, MD

The Education of the Pediatrician Workgroup is looking at the lifelong learning experiences of pediatricians, with an emphasis on graduate and continuing medical education. The Workgroup is considering the impact of new technologies on medical education, the credentialing process, and educating nonphysician providers of child health care. At its first meeting held on November 3, 1996, in Chicago, the Workshop discussed the need to build methodologies to ensure that changes brought about by the recommendations for the future of pediatric education are measurable. In the coming months, the Workgroup will be surveying pediatricians in their early years of practice to gain their perceptions in regard to what they found most valuable about their medical education and training, and about the availability of opportunities for continuing medical education (CME). this Workgroup will be

looking more closely at education issues for subspecialists and the interface between subspecialists and generalists in medical education.

Pediatric Workforce Workgroup Members:
Ralph Feigin, MD, Chairperson
Catherine DeAngelis, MD, Vice-Chairperson
Thomas DeWitt, MD
Lewis First, MD
Robert Kelch, MD

The Pediatric Workforce Workgroup met in August and reviewed a significant volume of material pertinent to workforce issues - ranging from the 1980 Graduate Medical Education National Advisory Committee (GMENAC) Report to the recently released Council on Graduate Medical Education (COGME) Eighth Report, Patient Care Physician Supply and Requirements: Testing COGME Recommendations. The Workgroup has reviewed trends and projections pertaining to the supply of pediatric services and the demand for pediatric care. This Workgroup has considered a broad spectrum of issues ranging from the demographics of the pediatrician population to the amount of pediatric care provided by nonpediatricians. They intend to look at the workforce implications of managed care, the rapidly growing percentage of physicians in internal medicine/pediatrics, potential reductions in the international medical graduate pool, forces driving graduate medical education reform, and other issues. The Workgroup plans to develop several scenarios to address the pediatric workforce of the 21st century.

Financing of Graduate Medical Education (GME) Workgroup Members:
Thomas Boat, MD, Chairperson
M. Douglas Jones, Jr, MD, Vice- Chairperson
Robert Adler, MD
Harfan Gephart, MD
Lucy Osborne, MD

The Financing of Graduate Medical Education Workgroup (GME) held its first full meeting on January 4-5, 1997. The Workgroup members Modified their specific Directives and determined that they needed to expand the scope of their charge to include both undergraduate medical education and continuing medical education (CME) - as well as GME financing issues. To this end, they are considering the different approaches to cost analysis and determing which are the most applicable to pediatric education. This Workshop met with representatives from several organizations to review a number of current and proposed funding methodologies (e.g. all payer system, voucher system, etc). An important topic of consideration is federal and regulatory (i.e. HCFA) efforts to control the cost of GME. The Workgroup also noted that, in addition to these methodologies, there are a number of commonly held "beliefs," such as the belief that a reduction in the number of residency slots equals a parallel reduction in the overall costs of GME. Some current topics before the Workgroup include: assessing the impact of the changing economics of health care; ti.. funding of pediatric subspecialty education; and the role and funding of pediatric CME teaching programs.

Pediatric Generalists of the Future Workgroup Members:
Peter Rappo, MD, Chairperson
Laurel Leslie, MD, Vice Chairperson
Herbert Abelson, MD
Renee Jenkins, MD
Sydney Sewall, MD

The Pediatric Generalists of the Future Workgroup is looking at the scope and practice of generalists and will define the future pediatric generalist. A large portion of the Workgroup's October 24, 1996, meeting in Boston was spent identifying resources and consultants that will be helpful in addressing its Directives. Currently the Workgroup is looking closely at the history of the evolution of pediatrics as a profession, how the role of the generalist will be shaped by the future health care needs of children, and how generalists will be affected by practice and external factors such as technology, managed care, the medicaid system, and the increased number of providers of pediatric care. The Generalists Workgroup is contacting members of the pediatric community (representing academicians, practitioners, academic generalists, and individuals with defined areas of expertise) for their insights on the future role of the generalist pediatrician.

Pediatric Subspecialists of the Future Workgroup Members:

Roberta Williams, MD, Chairperson
Alan Gruskin, MD, Vice Chairperson
Edward R. B. McCabe, MD
Fernando Stein, MD, PhD
Jeffrey Strickler, MD

The Pediatric Subspecialists of the Future Workgroup is looking at the need for, and accessibility to, medical and surgical subspecialists, the degree to which primary care is provided by subspecialists and vice versa, and issues surrounding referral practices. At its November 2, 1996, meeting, the Workgroup spent much time identifying data needs and developing strategies for getting input from subspecialty organizations and subboards. This Workgroup to collect demographic data on subspecialists. The Subspecialists Workgroup will get information from Department Chairs (via the Association of Medical School Pediatric Department Chairmen) on the current number of pediatric faculty and fellows as well as plans for future growth.

Survey of AAP

As one component of the Project, the AAP Department of Research will be surveying pediatrician subspecialists and generalists with subspecialty interests as to the nature of their practices as well as their educational needs. A two-part questionnaire will be administered - one part is standard, the other part is subspecialty specific. The questionnaire will be sent to each member of the 25 medical and surgical AAP sections. In addition, subspecialists who are not members of the sections will be surveyed, with the assistance of the American Board of Plediatrics (ABP) and other organizations that represent subspecialty pediatricians. The questionnaire will solicit information on: respondent's training, current employment activities, productivity and workload, patient characteristics, payment systems, and community characteristics.

Project members are interested in getting feedback and ideas on the following issues:

- Project members are interested in hearing from pediatricians who are in their earlier years of practice to learn what they found most valuable about their education and training, and if there are areas in which there was a need to seek increased expertise. Are there changes to pediatric education that could be made to help the typical graduate be more capable of handling primary care problems and more capable of handling primary care problems and more prompt in recognizing the need for referral? Insights provided by those practicing in managed care settings or in the types of practice arrangements likely to be prevalent in the future are especially encouraged.
- Project members are interested in getting feedback from pediatricians in regard to their opportunities for obtaining continuing medical education (CME) and any barriers that may exist to implementing changes in practice resulting from knowledge gained through CME.
- Project members are interested in learning about innovative teaching strategies that may exist. For initiatives that are community focused, Project members are interested in learning about the costs and time involved and how to evaluate the quality of education received.
- As more health plans feel pressure not to refer out, subspecialists may be serving as both subspecialists and generalists. Project members are interested in hearing from those who may be doing this, particularly with regard to their training, whether they feel they can remain competent in both subspecialty and general pediatrics, and how much time they need to spend in each area they need to keep up their competencies.
- Innovative models exist for providing preventive services in terms of behavioral pediatrics and adolescent medicine. Capitation and gatekeeping often serve as barriers to providing these services. Project members are interested in learning more about innovative models - examples might include an office that provides patient access to a psychologist, or an adolescent clinic located in a shopping mall.

- Models are being utilized that provide consultations to rural practitioners or to others who are part of a health plan but located a significant distance from a subspecialist. Project members are interested in learning more about these types of arrangements.
- Project members are interested in learning more about innovative ways the pediatrician can interact with the community, schools, public health agencies, service organizations, and parent support groups in delivering care in the future.

UPCOMING MEETINGS

COMSEP/AMSPDC:	March 6-9,1998 Sheraton Bal Harbor, Ft. Lauderdale, FL
AMSPDC:	March 4-8, 1999 Saddlebrook Resort Tampa, FL
COMSEP:	March 25-28, 1999 Galveston, TX

What the Dean Really Means

To the Editor: I submit the following guide for interpretation of what the dean really means:

THE DEAN'S LETTER	WHAT THE DEAN REALLY MEANS	THE DEAN'S LETTER	WHAT THE DEAN REALLY MEANS
Sensitive	Cries easily	Grasps new concepts quickly	Basically stupid, but flexible
Very sensitive	Cries on Rounds	Highly satisfactory	About average
Very cooperative	Easy; will work extra nights	Compulsive, goal-oriented drive	Obnoxious, but more so than the self-motivated individual
Relatively good	Would not want him for my doctor	Recommended to you with confidence	Glad to get him out of our school
Sensitive to patients' needs	Steals food from their trays	Recommended to you without reservation	Glad to get him out of our school
Extremely capable	A little better than average	Look forward to watching this individual as he matures in his career	Hope the turkey improves
Well-liked	His mother always spoke well of him	Will be an asset to your program	Don't call us, we'll call you
Extremely conscientious	Probably paranoid		
Assertive	Real S.O.B.		
Self-motivated	Obnoxious		
Outstanding integrity	On parole; is watching every step		
Enthusiastic	Hebephrenic		

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