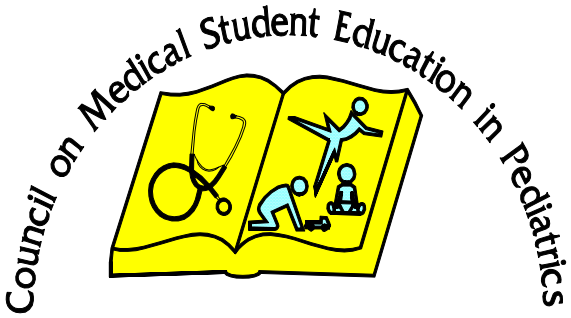
The Pediatric Educator



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Editor:
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President's Message

Hello everyone. I am writing as the new Interim President of COMSEP. In the aftermath of the tragic loss of our friends, colleagues, and leaders, Steve Miller and Richard Sarkin, we have witnessed new challenges. In many ways it has highlighted the true nature of this wonderful, compassionate, and resilient organization we call COMSEP. Networks of communication and sharing were developed rapidly after the accident to support each other and the families. Groups of members gathered at meetings and memorials. Personally, the support I received from members was critical to my process of healing and I believe this to be true for others also. Organizationally, the executive committee moved quickly to restructure and plan for the future. Out of this tragedy we move forward stronger and even more committed to following the passions of our departed leaders as we pursue our mission of educating future physicians to care for children. We are now at a point to experience a fantastic COMSEP meeting and to celebrate the lives of Steve Miller and Rich Sarkin as part of that meeting.

In this issue of the Educator you will still find the excellent journal club reviews we came to expect from Steve and his reviewers. A BIG thank you goes out to Karen Wendleberger-Marcdante for jumping in and organizing it. You will also see what exciting activities each of the task forces has planned. Please be thinking how you will get involved at the annual meeting. Information about new LCME interpretations is included and COMSEP task forces are ready to help members address these new regulations.

The Annual meeting planned by Michael Lawless and his organizing committee will be outstanding. This meeting was really Steve Miller's meeting and both Bruce Morgenstern and I will chair it in his honor. I look forward to seeing you all there!

Robin Deterding	Steve Miller
Interim President	President In Memoriam

2005 COMSEP Meeting

It's that time again! The 2005 annual meeting of COMSEP: Releasing the Imagination: Encountering the Arts in Education will be held April 7-10, 2005 at the Grandover Resort and Conference Center, Greensboro, North Carolina. Imagination allows us to extend our borders and be creative in our teaching, in our research and in our personal growth. The meeting will feature presentations and

workshops related to our theme, as well as an exciting selection of other workshops, task force sessions, poster and platform presentations of our research. Mike Lawless, Marcia Wofford and Dottye Currin of Wake Forest University School of Medicine are the meeting hosts.

Keynote speaker is Scott Noppe-Brandon, Executive Director of the Lincoln Center Institute for the Arts in Education in New York City. www.lcinstitute.org The internationally known institute has a dual commitment to education and to the arts. Mr. Noppe-Brandon's presentation on Friday will expand our view of the arts as a resource for exploration, reflection and understanding. A teaching artist from Lincoln Center Institute will conduct a workshop Friday afternoon utilizing listening to music performance as a means of stimulating the imagination. Twenty other workshops will be presented in three separate sessions of seven simultaneous workshops. The pre-conference workshops on Thursday, April 7 will include a workshop for new clerkship directors and a workshop on qualitative research in clinical medicine.

The plenary session on Saturday will provide an opportunity to remember and celebrate the lives of Richard Sarkin and Steve Miller, two of COMSEP's most esteemed members, tragically killed in an airplane crash in October. Both of these outstanding educators were excited about the theme of this meeting because of their personal love of the arts. The session will include a tribute to Rich and Steve followed by a presentation which will incorporate the arts as a means of dealing with grief and loss that we all encounter in our personal and professional lives.

There will be an optional Friday night activity that includes an on-campus dinner and tour of Winston-Salem's nationally known North Carolina School of the Arts. Our Saturday evening social will be at historic Old Salem, an authentically restored colonial community settled in 1776. Visit the COMSEP web site, www.comsep.org for details and the full meeting program; also for information on registration and hotel accommodations. You may contact our meeting planner, Lisa Elliott at LHE@abpeds.org for questions not addressed in the mailed or web site meeting information.

Michael Lawless, MD
Wake Forest University School of Medicine.

Hot Topic

In the last issue of the Pediatric Educator (Volume 11 Issue 2 Summer 2004) under the COPE Update section, I raised the issue of the LCME recommendations that were issued in June 2004. This resulted in a meeting between a group of COMSEP members and Dr. Simon from the LCME. The following is a report from that meeting.

LCME meeting summary, November 8, 2004
Where: AAMC meeting, Boston MA,

Attendance: Robin Deterding, Bruce Morgenstern, Sherilyn Smith, Chris White and Frank Simon (LCME)

Here is the LCME Requirement as presented in the Pediatric Educator:

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

Comments about the discussion with Dr. Simon:

Questions:

1. Is this a new requirement? Why the focus? He stated that this is not really a new requirement, but rather a revised interpretation of the original requirement, as many medical schools were evidently not doing a very good job of ensuring their students had appropriate experiences (relying simply on raw numbers, and not even doing that very well).

2. How do you define patients?
An important issue is how we define "kinds of patients" or the "variety of patient encounters." We are not locked in to using diagnoses or diseases in categorizing patients. It is the clerkship director's responsibility to define this requirement. We can use a variety of other classifications including:
- Ages/Developmental Stages: neonate, infant, pre-school, adolescent, etc
- Systems-based Categories: Pulmonary disease (or condition), cardiac condition, febrile children, etc.
- Classification of illnesses: Well child, acute minor illness, critical care, chronic disease, developmentally delayed, etc.

3. What is a clinical learning experience?
A major part of the discussion dealt with the issue of what should be considered an appropriate "clinical learning experience." He felt that simulated patients could come in a variety of forms, including "paper cases" (I'm not sure what this would look like), and computer-based simulations. It sounds like CLIPP would easily be considered a simulation. However, a central point seemed to be that simulations need to be experiential. We felt that this meant to some degree that students had some independent learning time. Currently there are no clear guidelines to understand what would be considered acceptable. Other discussions centered on what other things could be considered a learning experience.
- Seeing a patient at the bedside on rounds (a patient followed by someone else on the ward team) might be considered an appropriate learning experience, if the clerkship director spelled it out that way.
- A lecture would not be considered a clinical learning experience, although I wonder about a case-based discussion on a single patient or group of patients with a condition. I don't see how this would differ from a "paper case." I guess the key would be that in a paper case, you could make sure that each student is actively participating, whereas in a group discussion, you might not be able to. (I wonder if you used some sort of "audience response system" if you could actually make this work, since it would enable you to track different students?)
- The important point is that the kinds of meaningful clinical experiences need to be clearly delineated in the clerkship curriculum, and there needs to be some way to track them.

4. Are there specific recommendations about how many patients/what types of patients should be seen?
   a. There are no specific recommendations about how many patients/what types of patients should be seen. This is really up to the clerkship director. Many different specialties are approaching this differently (e.g. family medicine requirements to see X% of the top 25 diagnoses)
   b. The LCME people sound like they do not want to be any more definite about the accreditation process than they already are. They are afraid that if they are more specific, they will force programs into a certain format. They are most interested in a clerkship that has appropriate objectives (the LCME will not define those for us), a means of tracking the accomplishment of those objectives, and a means of intervening when students are not accomplishing them.
   c. COMSEP may consider providing guidance around ranges of clinical exposures with rationales.

5. What is the process to insure that clerkships meet this requirement?
   a. Make sure that the clerkship articulates goals and objectives about the nature of the clinical experience

b. Have a tracking system to insure that students meet the requirement

c. Have a system in place to fill in deficiencies when students are not meeting the requirements

6. What are common problems programs have had?

a. He noted that simply having logs is not adequate. Programs that use logs to document the experiences that students had (emphasis on the past tense) at the end of their clerkship (or the end of the academic year) are not being proactive in monitoring their curriculum. They are simply documenting what their students have done. He said that the spirit of the new rule is that there should be some mechanism in place to monitor the progress of each student's clinical experience, and intervening in "real time" to provide additional experiences, if necessary, for the student who was not meeting clerkship objectives.

b. Having no specific objectives…it is no longer sufficient to assume that students will receive adequate training b/c they were "on the wards."

c. No real time ability to intervene when students are not meeting requirements.

General comments about the LCME review process:

- It is not fair – whoever comes for the site visit does not actually vote on the accreditation process. They simply file a report, and then it is voted on by the LCME.
- Different LCME members have different backgrounds, and therefore, they do not view the accreditation standards in a consistent way.

LCME door is "always open" for us to comment on standards, but we will not be part of the process (Bruce tried).

What can COMSEP do to help its members understand and implement this specific requirement?

1. Encourage the reflective process about whether their clerkships are meeting the requirement.
2. Develop examples of how one might articulate this part the goals/objectives of the pediatric clerkship curriculum based on the format of the COMSE curriculum.

3. Develop strategies/tools of how to monitor this requirement.

4. Develop and disseminate tools to assess the compliance with the requirement.

5. Develop a list of examples of alternative patient experiences that clerkship directors could consider using if specific curricular requirements are not being met by their students. (This might include suggested formats, time requirements and experience from other institutions using these learning tools.)

6. Consider suggesting number ranges of clinical experiences (i.e.: 3 infant examinations), expected level of competency, and rationale.

In summary, we can (and probably should) be very limited as to the specific objectives we place in a new curriculum. The Curriculum Task Force has been working on a revision and this may help the process. There may be a role for major and minor objectives, and the majors are the ones that should be counted for the necessary quantification. The "major" objectives should be essential skills and/or knowledge elements; the "minor" objectives should represent desirable skills and/or knowledge elements.

COMSEP is prepared to work to address this new interpretation through the work of the curriculum and Evaluation Task Force.

ACE report for Educator

Bruce Morgenstern and Chris White

ACE, the Alliance for Clinical Education is, as we always write, the organization of clerkship directors' organizations. For more explanation, see their home page: http://www.allianceforclinicaleducation.org/index.html

Bruce Morgenstern, Michael Potts and Cynthia Christy now represent COMSEP. Robin Deterding, as interim president of COMSEP is also invited to participate in ACE activities. ACE meets once a year, at the AAMC and 4-6 times a year by conference call. The ACE President is now Lou Pangaro. COMSEP members have led ACE more than any other group (OJ Sahler and Fred McCurdy both served as Presidents). The ACE administrator is Gary Beck from Nebraska.

Current ACE initiatives include the 3rd edition of the Clerkship Directors' Guide. Led again by Rhee Fincher from MCG, the editorial board, or G8, is comprised of representatives from each member organization of ACE. The G8 selected the lead authors for each chapter and ensured wide representation from all member groups. Many of you volunteered to participate. At the moment, chapter leads are contacting sub-authors. If you have not heard by this point, it is unlikely that your services will be needed. The goal is to have something available electronically by the end of 2005.

ACE has developed a collaboration with the journal, *Teaching and Learning in Medicine*. COMSEP will publish selected abstracts from our annual meetings on a regular basis in the future. We will also likely participate in an annual "Journal Watch," in which COMSEP members will review educational articles that have appeared in pediatric journals, and therefore may not have been read by our colleagues in other disciplines. Steve Miller had been our lead on this project.

ACE is working with the AAMC and Eugene Corbett on a task force to develop a statement on the acquisition of clinical skills. Sandy Sanguino, Ben Siegel, and Bruce Morgenstern represent COMSEP on this task force. A draft document has been developed and is now at the AAMC awaiting feedback.

ACE is also determining how to work with the LCME to help clerkships meet the revised LCME standard that requires numbers and kinds of patients to be listed and monitored. COMSEP has taken the lead in this matter and has already met with a representative from the LCME. There is more on this in this newsletter.

At the 2004 AAMC meeting, there was an ACE-sponsored workshop on "Technical Skill Requirements for Third Year Clerkships." A representative from each of the seven major clerkship organizations was asked to present his/her organization's response to the following question: "Does your specialty have any technical skills in the third year clerkship that are mandatory for graduation such that if a student cannot/does not demonstrate the ability to perform the skill, they should not graduate?" This was then to be followed by a discussion among presenters and participants.

Chris White represented COMSEP on the panel. Gene Corbett, Chair of the AAMC Taskforce on Clinical Skills Education of Medical Students, and Peter Scoles, from the National Board of Medical Examiners also spoke.
Chris' answer to this was "No." Pediatrics (COMSEP) has not yet recommended any specific technical procedures that must be demonstrated in order to be eligible for graduation. Reasons for this were primarily practical:

- Students infrequently perform even relatively common procedures. They are often done by nurses or specialized teams.
- The logistics of requiring these procedures as a requirement for graduation would be a huge challenge to many institutions.
- There are ethical issues to consider when doing procedures on children, and practically, many parents are not willing to have third year students perform procedures on their children.

Having said that, Chris then discussed what skills are important for pediatrics that might possibly be considered for recommendation? His list included:

- Swabbing a throat for a throat culture
- Immunization administration
- Calculation and administration of IV fluids for maintenance and dehydration
- Oral rehydration
- BLS (particular emphasis on bag-mask ventilation, not intubation)
- Performing a competent history & physical

exam on children from birth through adolescence

He particularly emphasized that it is more important that medical students be able to competently evaluate children of all ages rather than focus on technical skills involving children. This was a major theme not only of this workshop, but also of other presentations at the AAMC. Students need to be taken back to the bedside, and taught better clinical skills, particularly in history and physical diagnosis of patients. That should be the primary focus of the pediatric clerkship, and not the acquisition or performance of technical skills.

CLIPP Update

This is an exciting time for those of us involved in the CLIPP project, as we are now in the implementation phase. Thanks to the hard of work of so many COMSEP members, the major goal of the project – broad use of the cases - has been realized. The total number of CLIPP cases completed in the last year is above 50,000, with 27 different schools each having more than 1000 cases completed. To the best of our knowledge, this is the most widely used computer-assisted instruction program in medicine!

Current work on the CLIPP project is focusing on how best to use these cases in the clerkship. We have put together a "CLIPP Working Group" of 6 COMSEP schools, and we will try to define successful integration strategies that result in increased student use, satisfaction, and perceived effectiveness of CLIPP. If anyone in COMSEP is interested in computer-assisted instruction has other research ideas involving CLIPP, we would be happy to discuss them with you. We are also working hard on some new, innovative modules to teach some of the tougher topics in medicine - Culture in Health, Children with Special Health Care Needs, and Genetics.

The CLIPP Working Group, led by David Levine from Morehouse, will be offering a workshop at the spring COMSEP meeting titled "Running Your Clerkship at a Good CLIPP." If you are interested in using CLIPP in your clerkship, or if you are using CLIPP but still need to know more about how to use CLIPP, this workshop is for you!

Error! Bookmark not defined., Leslie Fall and the CLIPP Working Group:
David Levine, Chris Maloney, Michael Potts, Ben Siegel, Sherilyn Smith, Venus Wilke

Task Force Updates

Faculty Development

Submitted by Bill Wilson

The Faculty Development Task Force has been active in anticipation of the April 2005 COMSEP meeting. A workshop "roadmap" is being developed, which includes an archive of workshops and other presentations from all of the previous annual COMSEP meetings. We anticipate that this will be posted on the COMSEP website, and should be useful to the membership and to those involved in planning the annual meetings and in developing ideas for workshops. Once again, many of the ideas developed at last year's task force meeting have materialized as workshops for this year.

Karen Marcdante has graciously agreed to coordinate the Journal Club, a favorite activity of Steve Miller, for this issue of the Pediatric Educator. Steve had started the journal club while he was co-task force leader, and had continued as the organizer and editor. We are interested in ideas (and volunteers) to help carry on this important activity, and will be discussing this in the task force at the upcoming meeting.

The "mentorship program" is gearing up for the April meeting. Invitations for volunteers to serve as mentors will be forthcoming by email after the

meeting information is distributed. This year's meeting will include a reception for new members, providing another opportunity for interaction. The "lunch with the experts" will continue, but will have a different format this year, with tables designated for specific topics.

We anticipate that the task force will be focusing on the workshop "roadmap" and our area of the COMSEP website at the 2005 meeting.

PS. The leadership of the task force consists of Leslie Fall, Angela Sharkey, and Shale Wong.

Curriculum Task Force
Submitted by Bill Raszka

The Curriculum Task Force (CTF) has been working on the Core Curriculum Revision Project. Issues that the CTF have confronted include the comprehensiveness of the curriculum, the overlap between objectives and competencies, and the lack of competencies in certain areas. Additionally, the CTF has been working with the Evaluation Task Force to define the core competencies unique to Pediatrics.

The first step in the process was to review all the objectives and competencies to decide which were core to the Pediatric clerkship. The objectives and competencies were reviewed for redundancy and then written exclusively as competencies. Those competencies considered critical in all medical students but not necessarily unique to Pediatrics were labeled as universal competencies (e.g. many professionalism skills and attitudes). Competencies that students should meet by the end of a clerkship rotation were labeled core pediatric competencies. Finally, competencies considered important to pediatric training but not necessarily part of the clerkship experience (e.g. more advanced knowledge or management skills) were labeled as mastery pediatric competencies. All chapters have been reviewed. The only outstanding chapter is that on acute minor illnesses. This chapter has been more problematic as any competencies in this chapter considered core pediatric will have enormous impact on the clerkships and how the clerkships respond to the LCME requirements regarding numbers of patients seen and documentation.

As needed, additional competencies have been written (e.g. sections on professionalism and chronic care have been updated).

The CTF has been working with the Evaluation Task Force and the APA Medical Student Education SIG to define the 10 core competencies in pediatrics and assessment tools for those competencies.

During the spring 2005 COMSEP meeting, the CTF hopes to finish work on the acute minor illness chapter after hearing input from the LCME and the Evaluation Task Force so that the new curriculum can be presented to the membership in later spring 2005.

Research and Scholarship Task Force
Submitted by Cynthia Christy

Our task force has had a busy year both finishing tasks from last year and planning for next year's meeting. We are completing a paper on a systematic review of teaching communication skills to medical students. Workshops are planned for both the COMSEP and PAS meetings on qualitative research methods. Rich Frenkel, PhD, on Qualitative Research will present the pre-conference workshop at COMSEP. This year at the COMSEP meeting members will be able to avail themselves of scholarship consultations set up through Sherilyn Smith. These will be in the form of a one-on-one session with a senior COMSEP member with experience producing scholarly works. Right now we are waiting for abstracts to review for the annual meeting. Discussions will take place at the meeting about combining our task force with Faculty Development to better meet the needs of our members.

The following contribution to the Educator is the Journal Review, which, since 1998, was edited by Steve Miller. Because of the tragic loss of Steve in October, there was question as to who would handle this daunting task. When approached by the COMSEP Executive Committee, Karen Wendleberger Marcdante agreed to serve as the "guest-editor" for this edition of the Journal Review. As Steve did in every edition of the review, I would like to mention that it was Karen's idea, in 1997, to develop a literature review of articles relating to teaching and medical education.-G.F.

Pediatric Educator -- Literature Review

In 1997, I piloted a journal club for the Pediatric Educator, highlighting an evidence-based approach to the education literature. That was all I did, although Steve Miller credited me in each edition that followed. However, it was Steve who served as the chief editor of this resource for us all since 1998. In his usual fashion, Steve used the Journal Club and reviews to help us learn, to keep us connected, and to highlight what our own members have done. I was touched when Robin and Bruce asked me to serve as the guest editor for this edition. I will miss Steve's comments and insight into each article presented.

Given the quiet newness of our loss, I, like others, took on this task in memory of Steve and Rich. So, many of the articles have to do with humanism, altruism and how to improve ourselves as educators. My thanks to the many reviewers who took the time to read and comment on the articles (see the list on the website). I know this was not an easy task this time. As for me, my comments were often prompted by the question: how would Steve and/or Rich view that? (You'll see that perspective-taking is an underlying theme for some of these articles and it seemed appropriate to try to view the pieces through the eyes of others.) Our own biases, of course, show through. I hope that you find this useful, learn at least one new thing, and reach out to someone to begin a collaborative effort to improve pediatric education. May the new year remind us of good times with old friends and bring us new colleagues, new ideas, and passion for life. Here's to Rich and Steve!

1. Benbasset, J and R Baumal. What is Empathy, and How Can It Be Promoted during Clinical Clerkships? *Acad Med 2004; 79:832-839.*

Reviewed by Sherilyn Smith, MD
This opinion piece is a good review of some of the basic definitions for empathy and how it might be taught and measured. The authors define empathy using a variety of methods and then briefly review the various teaching methods. They also provide evidence that students' empathy decline as they progress throughout their undergraduate training. This finding is the basis for their assertion that the "skill" of empathy should be reinforced in the clinical clerkships. The focus of the author's approach to teach empathy is to reinforce a "patient-centered approach" to interviewing. By adopting a patient-centered approach, students identify patient concerns, and this understanding provides the basis of engagement. Engagement then produces compassion, which leads to the desire to help the patient. The authors go on to outline the basic elements of patient centered interviewing and then target specific behaviors (that are reinforced in the clerkships) that are barriers to empathy (e.g. engagement via patient-centered interviewing): writing up the medical history during the interview, focusing too early on the chief complaint, and performing a complete review of systems.

Overall, the authors give a balanced view of the approach and I enjoyed the overview of patient centered interviewing. This article outlines the tension between competing educational needs. For instance, having students focus on the chief complaint early so they can ask appropriate questions competes with adopting a focus on patient concerns. What I felt was missing were some strategies to resolve these competing agendas. How can I help students adopt a patient-centered interviewing style AND bring the pieces of the patient's story together in order to develop a well integrated assessment and plan? Also missing were outcomes linked to the interventions that demonstrate that the students empathy did not decline following modification of these habits. (Maybe that study is coming!) Finally, the authors did not comment on the important issue of faculty

development in this area. If we, the teachers, are unsure about our own educational priorities and what we wish to model (e.g. patient-centered interviewing), we risk paying lip service to an important idea and unknowingly contribute to the decline of empathy in medical students.

It wasn't surprising to me that empathy declines with time. We see the decline all the time and attribute it to the workload and the need to "detach." It seems to me that by downplaying the importance of empathy we tacitly approve of our superficial approach to patients (and emphasis on disease). I, too, was hoping for some suggestions of things that work. The authors do recommend a single study of an intervention in a clerkship – having a small group of students meet to discuss some of these issues explicitly. The study was published in 1979! What a shame that we haven't built on this. Or have we? Have you tried to introduce some time to address empathy and altruism in your clerkship? Has your intervention worked? Have you disseminated your successes? KM

2. Rohenhauser, P, Strickland MA, Gambala, CT. Arts-Related Activities Across U.S. Medical Schools: A Follow-up Study. ***Teach Learn Med 2004. 16:233-239.***

Review by Sherilyn Smith, MD
This article is a follow up of a survey done in 2001 that reported on the frequency of art related teaching that occurs in medical schools across the country. Surveys were mailed to all US medical schools with a 65% response rate. Approximately ½ of the respondents indicated that there was some curricular component that linked arts and medicine. Twenty-six schools reported required courses and 43 schools reported elective courses. The curricula for these courses were varied as were the type of art form utilized (writing, literature, art, music etc). A majority of the respondents (52/83) indicated that there were extracurricular student activities, and these were often used to promote student well being (vs. teach specific skills). The curricula from selected schools were highlighted to give a flavor of what might be accomplished in these courses (and we have seen some excellent examples from COMSEP members!!!). The article highlights that very few courses have reported evaluation or assessment of specific outcomes.

This article clearly demonstrates that many schools believe that inclusion of the arts and humanity in medical student training is important and worth the investment. Further work needs to be done to articulate what we are trying to achieve with our educational interventions and move to creatively and accurately measure these outcomes.

I immediately thought of Rich Sarkin when I read the title of this article. While I never experienced his use of art to teach pediatrics, I heard it was quite impressive. I wish we could hear more about his work. Sherilyn points out that several COMSEP examples were used. (Congratulations!) Perhaps its time for us to do something collaborative – and to consider what impact this actually has. Do you think that the time spent on teaching these non-science components is appropriate? Will a student who is exposed to a different approach (as may come from these diverse topics) be a measurably better physician? KM

3. LeBaron S. "Can the Future of Medicine Be Saved from the Success of Science?" ***Acad Med2004;79: 661-665.***

Reviewer: Randy Rockney, MD
As I read this article I kept thinking about Rich and Steve. It asks the reader to meditate upon all the things the two of them represented and ultimately gave their lives to promote.

The author is the director of the Center for Education in Family and Community Medicine at Stanford University School of Medicine. The article is an edited version of his acceptance speech when he received the award for Humanism in Medicine, presented by the AAMC in 2003. His primary message or the one, as he says, "as big as the ocean," is that "the fundamental connections that we physicians have with each other and with our patients are endangered by an illusion that scientific knowledge is The Key to well-being and health." He connects physicians' unhappiness with their work with patients' dissatisfaction with their health

care. He emphasizes that, "our work as physicians is not only about science; it is equally about life stories and caring for people who suffer." He does not deny the miracles that have come about through advances in scientific knowledge and technology, but he does perceive a loss of balance between knowledge (science) and wisdom (humanism). The point of his essay is to urge us as physicians to recreate that balance. A good place to begin, he suggests, is to stop beating up on ourselves (my words, not his) and recognize that "we physicians are entirely as human as our patients." He cites episodes from his own personal development as a physician where he, fortified by poetry, learned to care for himself as well as others and urges us to do the same. In his personal journey he learns that becoming a compassionate being is not an unattainable goal but instead requires the practice of being "intensely together with those who suffer." He ends the essay with a beautiful and moving story of his reaching out to a seemingly forever withdrawn and dying child to bring that child and his parents back together at the end of the child's life.

Comment: This is a lovely essay and one worthy of being read by everyone in COMSEP and probably by every physician. I found the title a trifle misleading as it seems to portend a bashing of science which the author takes pains to avoid. Besides, any article that opens with a reference to opera, in this case *La Boheme*, has got a lot going for it in my book.

I couldn't agree with Randy more. Take a moment right now and read this article. As we all face the increasing pressures and observe many of us (?including ourselves) become more disengaged with our chosen profession, the message of Dr. LeBaron and our own dear colleagues, Rich and Steve, is needed more than ever. While not part of a publication, our members' many beautiful words about Rich and Steve's passions and every day inclusion of humanism and altruism (posted on the listserv) highlighted just how each individual could make a difference. Have you taken a moment today to view things from someone else's perspective? Have you been "intensely together with those who suffer?" Some days it seems like just too much to add to the already crowded hour, but don't you feel better after reaching out in that very human way?KM

4. Delva DM, Kirby J, Schultz K and Godwin M. "Assessing the Relationship of Learning Approaches to Workplace Climate in Clerkship and Residency" ***Acad Med 2004;79:1120-1126.***

Reviewer: Leslie Fall, MD

While the goal of medical student education is to foster independent, self-directed, lifelong learning, little research has focused on the effect of the workplace on learning styles during the clinical training years. Previous work with pre-clinical medical students, nurses, and practicing physicians demonstrated that high workload is associated with a "surface/disorganized" learning style, while a supportive-receptive and choice-independent workplace is associated with "deep/organized" learning (see paper for definitions but it is safe to say that surface/disorganized is not a style we hope to promote). To further investigate, the authors surveyed all 532 medical students and 2,939 residents in the 5 medical schools in Ontario, Canada, using a modified, previously validated Approaches to Work Questionnaire, containing 30 questions about approaches to learning and 15 questions about perceptions of workplace climate. The combined response rate was 47.3% (student-only response rate not reported). The findings in this study were similar to those studies of other groups noted above. Of note, interns were most likely to adopt a surface-disorganized approach to learning, and medical students perceived less support in the workplace than did residents. Significant differences were noted among various specialties. (Pediatrics was not broken out specifically). The authors conclude by stating that these relationships may indicate that teachers may be able to positively affect learning and perceptions of a busy workload through specific modifications of the workplace. The authors raise interesting questions about the effect of one's intrinsic learning style on specialty choice, and the role of age and experience in modifying one's learning style in a given work environment.

The attempt to balance the service and educational

components of clinical training has always been a difficult task for medical teachers. Not surprisingly, this study demonstrates a clear relationship between a high workload and adoption of ineffective learning styles, particularly for interns. I like their suggestion, however, that modification of the student and resident work environment (i.e. more learner choice, increased support by the teacher), may "lighten the load" of a busy service. Hmmm, sounds like a good point for faculty development!

This wasn't an easy paper to read. Like Leslie, I wasn't surprised by the findings. I was stuck that it doesn't make a difference what the faculty see as "the workload." Learning styles are dependent on how the students/residents perceive the workload. So, regardless of our views of comparative workload (e.g. When I was a resident I didn't get to leave after 24/30 hours), our ability to promote a more effective learning style (and perhaps more efficient patient care style) depends on acknowledging learner perceptions and supporting learners through their perceived challenges. Have you been dismayed when students demand "Just tell me what's on the test?" Or ask for the answers to the vignettes – why should they spend time finding the answers when we(the faculty) know where they are? As I've aged, I've thought of this as a generational problem (those youngsters, you know and perhaps a sign of laziness). Now I have to consider that somehow the learning environment we have created is overtaxing and the students are doing what we all do – falling back to a superficial/disorganized approach. Perhaps its time to investigate the students' perspectives on workload and pilot some interventions that will help them move to the deeper/integrated learning styles we all hope to promote. Any ideas? KM

5. Kalet A, Hopkins MA, Riles T. A rapid clerkship redesign to address new realities. *Medical Education, Volume 38, Issue 11, Page 1193-1194, November 2004.*

Reviewed by Linda Tewksbury,MD

This article briefly outlines the process used by a surgery clerkship at NYU School of Medicine to undergo a rapid redesign through a systematic assessment of needs, implementation, and evaluation. Driven by a school mandate to reduce the length of the clerkship (from 10 to 8 weeks) and the recognition of dissatisfaction by both students and faculty with the "traditional clerkship model," the group used both qualitative (focus groups, surveys, in-depth interviews) and quantitative (test scores) assessment tools for pre/post evaluation of the new curriculum. Specific flaws in the curriculum (i.e. unclear structure, poorly defined core clinical content) were addressed by creation of clearly defined objectives and expectations for the students and teachers. Additional teaching models were introduced including newly designed asynchronous web-based multimedia learning modules (replacing lectures) and skill lab sessions. The curriculum was expanded to include communication skills and ethics. Criteria for evaluation were clearly defined and disseminated. Faculty and residents were evaluated on their teaching by students and given personalized feedback as well as opportunities for faculty/resident development.

Post-evaluation results included improved satisfaction and attitude of both faculty and students, no change in knowledge test scores, and an increase in student interest in pursuing general surgery as a career. Although details were not provided in this brief report, it is a good example of how positive change in a curriculum can be rapidly implemented through a systematic approach that includes qualitative and quantitative methods for assessing needs and evaluating results.

Improving our clerkships always seems like a daunting task. These authors use solid educational methods to introduce change. All too often, an urgency to change results in a more haphazard approach. Looking at some of the other articles we reviewed in this edition of the Educator, perhaps we could use the systematic approach delineated here to help us incorporate a few innovations. Do you have a group of people who could help you complete a needs assessment? Identify gaps? Create and introduce new activities that are linked to measurable outcomes? Do you have any successes that you would like to share? KM

6. White CB, Thomas AM. Students Assigned to Community Practices for Their Pediatric Clerkship Perform as Well or Better on Written Examinations As Students Assigned to Academic Medical Centers. ***Teaching and Learning in Medicine. 2004; 16(3):250–254***

Reviewed by Bruce Morgenstern, MD
In another paper by a COMSEP member addressing the impact of the clinical experience of students on their performance on written examinations, Chris White of MCG, along with Andria Thomas from the Department of Family Medicine, evaluated the cumulative experience of students over 5 years. They report that of the 830 students, the 173 students who were at Community Practice Sites (CPS) did at least as well, if not better than those who were at Academic Medical Centers (AMC). The NBME subject examination scores did not differ. CPS students did better on an in-house MCQ type exam. They also had a statistically better clinical grade (but I wonder if there is a meaningful difference between 90.3 and 88.9?). Students at CPS saw many more patients (167 vs. 71).

Comment: In an era in which the LCME has created a new emphasis on "numbers and kinds" of patients, this paper adds meaningfully to our data set. The student results at MCG are not dissimilar to results seen in Nebraska. The results do differ from data reported in surgical clerkships, and at least one other Pediatrics site.

Before we place too much emphasis on the parts of this study, which imply that students at CPS did better, we need to look at those outcomes. White and Thomas argue well that the clinical grade is not a meaningful tool, given how subjective clinical grades often are. They do not spend much time letting the reader know much about their in house exam. Is it reliable? Is it valid? Is there a pro-ambulatory bias to the exam? Perhaps they have sufficient data to analyze their exam to see if the differences are real. Despite these weaknesses, it is clear that students in different sites do no worse. This adds to the questions that underlie the move of the LCME to "numbers and kinds." Is there a dose-response effect to clinical education? Is there some useful and valid measure of "equivalence" between clinical sites in clerkship? Certainly, the MCG students seem to have disparate experiences (as did those in Nebraska), but they seem to be able to test out the same. Perhaps it's true, our students are chosen to be able to succeed despite us. We have an important need to continue investigations along the lines of this paper.

Bruce raises good questions about the evaluation data we use. I know that many of us have a less than accepting response to the LCME requirements. Why is diversity sometimes a good thing, but not acceptable at other times? Since the LCME standard isn't likely to go away, and we have several studies that suggest that diverse exposures do not have major impact on our measured outcomes, I'd like to pose a different question. What was similar in the various experiences that resulted in similar outcomes? Isn't that what we should quantify and use as our "numbers and types?" Maybe it is because we know that pediatrics can be taught during interactions with a variety of patients and diagnoses, that we have created systems that allow students to learn the basics of pediatrics regardless of the type and number of patients they see. Can you think of other groupings that will meet the needs of the LCME and the experiences of your students? I think that the studies may help us look at things from a different perspective and create a solution that helps us train great doctors. KM

7. Hasnain M, Connell KJ, Downing SM, Olthoff A and Yudiwsky R. Toward Meaningful Evaluation of Clinical Competence: The Role of Direct Observation in Clerkship Ratings. ***Acad Med 2004; 79(10):S21-4.***

Reviewed by Bob Swantz, MD
This paper addresses the question of whether direct observation by faculty of students' clinical skills improves the reliability and validity of their ratings of student performance. The study was a retrospective review from one academic year of a class of third year students on a six-week family medicine clerkship. Faculty ratings of clerkship performance using a 16 item behavior-based assessment tool were assigned weighted scores

depending on the basis for the rating – note review, case discussion, and direct observation (low to high score data sources). These assessments were compared with NMBE subject exam scores and results of a 4th year 8 station OSCE (employing standardized patient).

Of 172 clerks, 73% had experiences at residency sites, and 33% had a single preceptor (who on average spent 11.5 half-days with student). Internal consistency on the assessment tool based on the primary evaluator was high (.93), however the overall coefficient for agreement between 3 raters was only .36. Subgroup analysis considering the data source showed that inter-rater reliability increased from .29 to .74 as more direct observation, instead of just note review, became the basis for judgment. While overall scores on the assessment tool also had a positive correlation with NBME subject exam scores and OSCE scores (r=.141, and r=.159, respectively), a similar sub-group analysis by data source, showed an even stronger and statistically significant correlation (NBME scores r=.311 and OSCE scores r=.423). The authors concluded that reliability and validity of student clinical competence ratings are enhanced by direct observation.

Comment: Although the study has some limitations (extrapolating data source ratings from the primary evaluator to all preceptors, and small number of subjects in sub-group analysis) it supports the argument for more direct observation to improve the reliability and validity of student evaluation. The poor inter-rater reliability when data source was not taken into account is not surprising. How many times have we seen discrepant evaluations of a student from faculty and residents, some who directly observe the student in their clinical skills and others who extrapolate inferences of performance from reading H&P's and progress notes? The article makes a case for employing multiple bases, including direct observation, to formulate judgments about trainees. The question remains – how can evaluators, within the time constraints of their practice, incorporate direct observation (even brief encounters) into their assessment of students?

We probably all agree that increasing direct observation would improve our evaluations. (How many of you have seen Bill Razka's brilliant demonstration, where he role-plays a student performing a focused history and physical (badly) and then, competently present it to faculty?) What I liked about this article, though, has to do with the variety of evaluation and measurement techniques the authors use. Do you know your inter-rater reliability for various preceptors? Do you weight the evaluation scores based on the degree of observation? Do you triangulate data? These are things for all of us to think about (and get help with, as most of us are not evaluation experts). Having said that, Bob hits the other real question right on the head: Who has the time or resources to increase direct observations? Some of our COMSEP members have helped us with some strategies – brief structured observations and structured clinical observations (SCOs) are two examples. But the time/money question is still there. So, I have a few other questions: Do your residents or faculty receive training in how to observe? Do you have systems (e.g. checklists) in place to help them standardize observations? And what about an understanding of what you observe for in areas such as professionalism? Altruism? Teamwork? I think it's time for us to use the wisdom of crowds and brainstorm about ways to increase direct observation that won't overtax our systems. I know we can do it! KM

8. Jones WS, Hanson JL, Longacre JL. An Intentional Modeling Process to Teach Professional Behavior: Students' Clinical Observations of Preceptors. ***Teach Learn Med 16(3):264-269.***

Reviewed by Karen Marcdante, MD

While the previous article talked about our direct observation of learners, this article, authored by several COMSEP members, demonstrates that direct observation of faculty can be an excellent learning tool. The background provides a nice review of some components of professionalism, how it is taught and what we know about how it is learned. Role modeling is a key component of how our learners identify professional behavior. Thus, the use of role modeling combined with a form

(based on Lindsey Lane's structured clinical observation form) to emphasize professionalism and interpersonal communication skills was described. This method was known as the Students' Clinical Observation of Preceptors (or SCOOP). Students were given the forms and instructed to observe an interaction between the faculty member and parent/patient. A post-encounter discussion would review what was observed, making things more explicit. The results are presented as the perspectives of faculty and students. It was positively received by 83% of the students although 24% felt uncomfortable critiquing their preceptor. A significant percentage of students (64%) were, at the end of the clerkship, able to identify one or more of the behaviors they were directed to observe. Only 5 faculty were involved and comments about their perspective are fairly broad, although the discussions of being "SCOOPed" focused on how faculty dealt with the unexpected arose (e.g. sensitive subjects such as non-accidental trauma). There is no information on the time it took to complete this or on the frequency of various discussions.

This article is a nice demonstration of the scholarship of application and innovation! The authors built on previous work (courtesy of Lindsey Lane and colleagues), modifying it so that the student is doing the observing. Knowing how often students comment on being passive learners, this is a great way to activate the students, providing explicit behaviors to watch for and then discussing their perceptions with the preceptor at the end of a patient interaction. I did find myself wanting more information about how the students were oriented to the information and what training the faculty required. I also wondered about some of the discussions. Did they occur after each session? Were there themes? If so, was there any interest in altering curriculum to make sure things were addressed routinely? I found the title a little misleading since much of what was described had to do with respect and interpersonal communication between physician and patient. However, that is part of professionalism. I also think it could be further modified to include some of the more "difficult" components of professionalism (e.g. honesty, duty, excellence, altruism and accountability) and am eager to pilot that. It is such a beautifully simple idea that it could also be used for other components of competency training. So, can you identify ways that SCOOPing would help in your clerkship? Would you focus on one area, such as communication skills, problem-solving, etc? What do you think you would learn about the students? Would it help you design better curriculum? What a lot of opportunities! KM

9. Kernan WN, Holmboe E, O'Connor PG. Assessing the Teaching Behaviors of Ambulatory Care Preceptors. ***Acad Med. 2004; 79:1088 – 1094***

Reviewer: John S. Venglarcik, III, M.D.
Kernan and colleagues have done all of us a favor by providing a mechanism to assess the teaching behavior of ambulatory preceptors in a reliable fashion. In recent years there has been a growing concern regarding the clinical skills instruction our students receive in medical school. The authors developed an instrument for measuring teaching behavior in an ambulatory setting then used the instrument to assess teaching behavior in their institution. The first step was to develop an instrument that they called the Teaching Encounter Card (TEC). The TEC included eight teaching behaviors: allowing student to complete the history and physical, hear full results of student evaluation, observe student performing part of physical exam, hear student assessment before giving one's own, ask questions beyond assessment and plan, hold discussion away from patient, observe student interviewing patient, allow student to do visit closure and provide feedback to student. The TEC was validated with third year students on the ambulatory portion of the internal medicine clerkship at Yale. Both the faculty and students received instructions on use of the card. Standardized patients and faculty scripts were used to complete the validation process.

In a field application, the sensitivity of the TEC was at least 80% for six of the behaviors (range 64% - 100%) and specificity was at least 80% for all nine behaviors and 100% for five. For the full trial 20 students completed the TEC for 17 preceptors and 270 teaching encounters. The preceptors used six

of the behaviors in over 70% of the encounters. The three exceptions were: observing student interview patient (68%), providing feedback (52%) and observing student perform part of the physical examination (24%). There was greater variability for behaviors that were used less often by the preceptors (e.g. observing students perform part of the physical examination).

Accuracy was particularly high for five behaviors: allowing student to complete the history and physical, observing student performing part of physical exam, hearing student assessment before giving one's own, holding discussion away from patient and provide feedback to student. The authors expressed concern that students failed to recognize the other behaviors in the preceptors. The authors concluded that the TEC provided valid information about the behavior of physicians who teach ambulatory care internal medicine. The TEC was well accepted by students and faculty. The ultimate utility of the card could be confirmed by its effect on faculty teaching behavior.

Comment: The authors undertook a difficult task in attempting to quantify ambulatory teaching behavior. What I liked the most, and what makes this article interesting, is that the authors validated the tool (TEC) before they used it to assess teaching behavior, making this a powerful study. The tool was simple, uncomplicated and easy to use (another study, on a smaller scale, used a PDA). Although I thought the procedure was correct, the relatively small number of observations (11 students engaged in only two different teaching encounters) may account for the wide variability of some values. However, this is a minor criticism as the sensitivity and specificity were both high. The authors also pointed out that the students themselves may not recognize some of the teaching behaviors and suggested that a way to improve sensitivity would be to train students to recognize certain teaching behaviors.

This is a good effort to quantify certain teaching behaviors and, hopefully, provide physicians with opportunities for faculty development. I am not certain about the utility of the entire TEC as designed for pediatrics. Some of the teaching behaviors might need some modification if applied to pediatrics or even be substituted by different behaviors. Any modification would require validation but perhaps we should consider making a similar attempt in pediatric ambulatory care.

As John mentions, this study is well done, including validation of their tool. It is also an important topic – how to provide more specific feedback to preceptors. Given the large number of preceptors we interact with and the generosity of our volunteer faculty this relatively simple method seems to be ripe for application. Would something like this help you give better feedback to your preceptors? As John questions, do you think we would need to change any of the behaviors for pediatrics? Would you preceptors welcome this?KM

And finally:

The Washington Post has published the winning submissions to its yearly contest in which readers are asked to supply alternate meanings for common words. And the winners are:

1. Coffee (n.): the person upon whom one coughs.
2. Flabbergasted (adj.): appalled over how much weight you have gained.
3. Abdicate (v.): to give up all hope of ever having a flat stomach.
4. Esplanade (v.): to attempt an explanation while drunk.
5. Negligent (adj.): describes a condition in which you absentmindedly answer the door in your nightgown.
6. Lymph (v.): to walk with a lisp.
7. Gargoyle (n.): olive-flavored mouthwash.
8. Flatulence (n.): emergency vehicle that picks you up after you are run over by a steamroller.
9. Balderdash (n.): a rapidly receding hairline.

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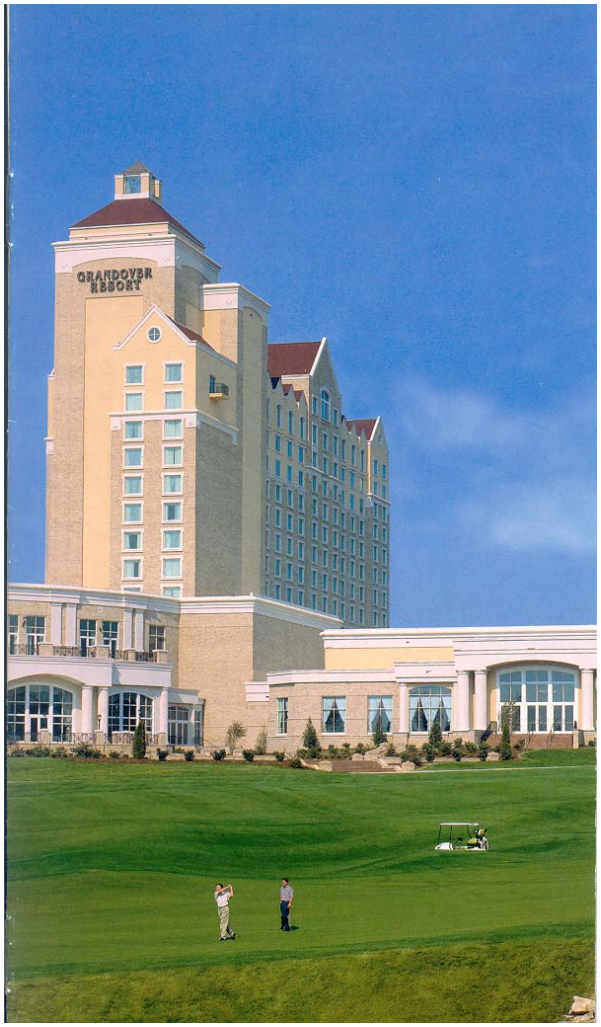

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