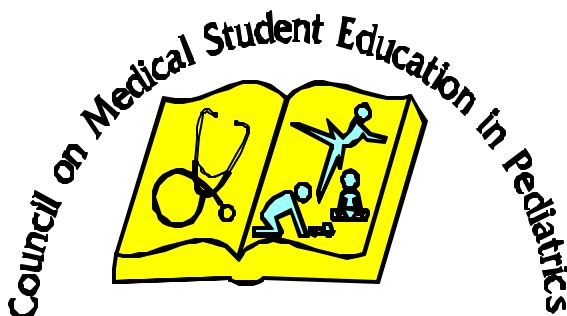


# The Pediatric Educator



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**Editor:**

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*President's Message*

Hello everyone.

Welcome to the long awaited Pediatric Educator!

In just 3 short months we will get to experience another fantastic annual COMSEP meeting, March 16<sup>th</sup> – 19<sup>th</sup> in Salt Lake City, Utah. Lisa Elliot, Chris Maloney and others have been hard at work to make this meeting outstanding. The workshops are excellent! It will be wonderful to see you all again. Make sure you mark your calendars! However, one thing to note and to plan for now: Thursday, March 16<sup>th</sup>, the day our meeting starts is Match Day. Sorry about this but we book years in advance and this was not appreciated at the time.

In this issue you will review updates on action items from the task forces that were developed at the last meeting in North Carolina. Some of these action items are already happening. It should give you a good look at the spectrum of what we do in COMSEP. I am amazed sometimes about the impact this organization has on pediatric medical education.

Speaking of impact, at this past Association of American Medical Colleges (AAMC) meeting,

Lindsey Lane was asked to participate with other clerkship organization representatives to review what we have done to address the LCME ED2 requirements. Lindsey did a wonderful job. It was clear that COMSEP was leading the way in what we have done in our Curriculum and Evaluation Task Forces to address these issues. Folks in the audience were impressed and I, of course, was very proud and so were the other COMSEP members in attendance!

Despite hurricanes and other issues that creep up when folks are trying to take on new responsibilities, I am happy to have our journal club return. Thank you to Judy Rowen (who saved the information from the waves in Galveston), the Faculty Development Task Force, and all who provided reviews. In this issue, I try my hand at asking Steve type questions at the end of each review. No, it isn't quite the same but it did make me smile.

I remain very excited about our opportunity to develop funded educational scholarship grants for COMSEP members! The Request for Applications (RFA) should be out in very soon. Please be thinking of your focused research question to apply.

My best,  
Robin

## Remember

March 16-18, 2006 - Hilton Salt Lake City Center, Salt Lake City, Utah. Pre-conference workshops will begin March 16 at 8:30 a.m., with the general session beginning at 2:00 p.m. on March 16. Meeting will conclude with a closing dinner on March 18, 2006.

## **Federation of Pediatric Organizations** **Report of the Task Force on Women in Pediatrics**

There are many reasons for addressing issues of family balance in the lives of pediatricians during training and practice, including concerns regarding productivity, career advancement, and individual fulfillment. The most compelling reason derives from the central responsibility of our profession. The commitment of pediatrics to the health and well being of children and youth should encompass the families of those who choose to pursue careers in pediatrics. Further, there are special issues and some obstacles that impact particularly on women pediatricians.

At each phase in the development of a pediatric physician there are a number of measures or steps that should be taken to promote the career development of women pediatricians and promote the best interests of children whose parents are or will be pediatricians. Some of these measures are gender specific; many are not and will benefit the next generation of men and women in pediatrics. The following recommendations should be considered in this context.

### A. Medical Student Education

1. During both the pre-clinical years and as part of clerkships in pediatrics, pediatric faculty should address the issue of the balance between parenting and other family responsibilities and professional responsibilities towards patients (and related ethical issues). This should include discussions of what is involved in good parenting, issues of parenting and professional careers as physicians that are similar and different for men and women, and the ways in which various kinds of pediatric careers (sub-specialist or generalist academic clinical practice, private practice, pediatric research, public health, etc.) interface with family responsibilities.

Responsible Organization: COMSEP

2. Pediatric faculty and department chairs should play leadership roles in creating family friendly environments within their medical schools including but not limited to the provision of child care, lactation facilities, and flexibility in progression through the curriculum for medical students who are parents and/or responsible for the care of ill or disabled parents.

Responsible Organizations: COMSEP and AMSPDC

3. The behavior of pediatric faculty in regard to the balance of career and family (A-1) and promoting a family friendly environment (A-2) should serve as explicit "models" for medical students.

Responsible Organization: AMSPDC should play a lead role in promoting such modeling.

4. Surveys conducted annually of medical students should posit questions addressing the family-friendly environment of medical schools.

Responsible Organizations: AAMC, ABP, AAP

### B. Pediatric Residency Training

1. Pediatric residency training should be conducted in a family friendly environment which should include, but not be limited to, provision of infant/toddler and after-school care, lactation facilities, and flexibility in the progression and design of training schedules and rotations for residents who are parents and/or who are responsible for the care of ill or disabled parents or other family members. A standard for rating "family friendly" programs should be developed by the AAP similar to the rating system for family friendly work environments applied to Fortune 500 companies. This standard for family friendly environments should be disseminated to medical students and residents. Residency programs that meet this standard should be publicly identified in pediatric journals, and in appropriate web sites, and brochures promulgated by the AAP (Peds 101), the APPD, and the AAMC.

Responsible Organizations: AAP, APPD, and

## AAMC

2. All pediatric residency programs should include the option of part-time or flexible training schedules. The availability of this training option can be an attraction to a career in pediatrics, promoting the choice of academic general or subspecialty practice or research as well as private practice. As measures of the ACGME competencies are developed and validated, these competencies should be incorporated as part of the decisions of program directors about the necessary duration and components of residency training that qualifies a resident for board certification by the ABP.

Responsible Organizations: The ABP, the Pediatric RRC, and the APPD should each play appropriate roles in facilitating and implementing this recommendation.

3. Understanding the parenting experience and related family issues are critical to the education of residents and the provision of quality health care to children and youth. Therefore, residency programs should be designed to incorporate identifiable relevant educational experiences related to parenting into the training of residents.

The process of becoming and being a parent contributes to one's growth and understanding of parenting—its challenges, its joys and its complexities—and child development. Further, this personal growth can be transformed into professional growth of a pediatrician, especially if structures are added to direct this growth and to allow for its evaluation or demonstration (ie, a paper, a lecture, or parental guidelines derived from reading the extant literature on parenting with personal insights). Programs should entertain the possibility of allowing residents to receive some credit for independent work occurring during their maternity or paternity leave (or other period of sustained, primary care for a child or children) to recognize and encourage the professional growth that can occur from such experiences.

The importance to pediatric residency training of understanding and being sensitive

to parenting issues should be acknowledged in policy statements by the APPD, ABP, AAP, and AMSPDC. This should also be a topic for a commentary by AMSPDC in the Journal of Pediatrics.

Responsible Organizations: APPD, ABP, AAP, AMSPDC

4. A long term publicly articulated goal of residency program directors, the APPD and the ABP should be to evaluate a resident's readiness for board certification based on measured competencies, rather than a fixed duration of training.

Responsible Organizations: APPD and ABP, with input from AMSPDC should work collaboratively to develop recommendations for such long-term change.

5. Directors of residency programs, department chairs and resident mentors should take into consideration during their career counseling the special needs of those residents who are parents or planning to be parents, including specifically the issues of balancing family and professional responsibilities. Facilitating understanding of and sensitivity to these matters is an important part of the RRC requirement for career planning and the FOPO policy on pediatric subspecialty fellowship programs.

Responsible Organizations: APPD, ABP and AMSPDC should develop guidelines in this regard.

6. The AAP and ABP surveys of medical students and residents should include questions about the family friendly environment of training programs.

Responsible Organizations: AAP and ABP

## C. Subspecialty/Research Fellowship Training

1. Directors of subspecialty fellowship programs should take into consideration during their career counseling the special needs of those trainees who are parents or planning to be parents, including specifically discussing the issues of balancing family and

professional responsibilities.

Responsible Organizations: Subspecialty Societies, AAP subspecialty sections, subspecialty program directors organizations, and the APPD.

2. The recommendations for a family friendly environment indicated in B-1 for residency should apply to subspecialty training fellowship programs and include after school child care.

Responsible Organizations: NACHRI, AMSPDC, and ABP should assume leadership roles in implementing and or facilitating this recommendation.

3. Federal loan forgiveness programs should be expanded.

Responsible Organizations: NACHRI, NICHD, and AMSPDC.

4. Universities/medical schools/teaching hospitals should include flexible spending accounts in their benefit packages that make resources available for subspecialty/research fellows (and residents) to purchase child care, after-school care, and care for sick and disabled parents, etc.

Responsible Organizations: AMSPDC should play a leadership role in advocating for such a benefit.

5. Balancing family life issues and professional responsibilities should be included in career mentoring of subspecialty fellows.

Responsible Organizations: Subspecialty Program Directors, the ABP, AMSPDC, and the APPD (to the extent that it includes subspecialty program directors) should advocate for the inclusion of these matters in subspecialty training programs.

6. Part-time and/or percent effort based support for subspecialty/research training should be made generally available by subspecialty training programs.

Responsible Organizations: Such fellowship positions should be advocated for and promoted by pediatric subspecialty societies, subspecialty sections of the AAP, and sub-boards of the ABP, and by the AAP, AMSPDC, and NACHRI. These professional groups should also actively advocate for similar part-time/percent effort arrangements in fellowships offered by federal agencies and foundations. RRC requirements should be supportive of or require that such subspecialty fellowship positions be available in all programs.

D. Junior Academic Faculty

1. The age requirements of academic professional organizations and federal and private fellowship and investigator awards should be adjusted upward to take into consideration the longer duration of training and leaves for child bearing, parenting, and elder care.

Responsible Organizations: AMSPDC and the AAP should take the lead in advocating for these changes in cooperation with the AAMC and NIH as appropriate.

2. The standards for a family friendly environment referred to in B-1 and C-1 should be applied to all pediatric departments. Departments meeting these standards should be publicly identified in announcements of available faculty positions. These standards should include provision for infant/toddler and after-school and elder care at this and subsequent stages of career development.

Responsible Organizations: AAP, APPD, AAMC

3. Junior faculty should be provided with career mentors from their own and/or other academic institutions.

Responsible Organizations: The APS and the women's SIG of the APA should play lead roles in making such mentors available to faculty who request them.

4. The pathways to academic success are becoming more diverse and part of the

responsibility of mentors is to help educate junior faculty about their options, guide them in defining and focusing their goals, and make them aware of the various measures of “academic success.” Department chairs and mentors should carefully advise junior faculty regarding appropriately balancing their need to protect their time for scholarly pursuits against their responsibility as faculty to participate in a variety of other institutional activities. These issues are often institution specific in regard to faculty advancement.

Responsible Organization: AMSPDC

5. Junior faculty and those finishing subspecialty fellowships need to become educated by their mentors about negotiating for appropriate resources necessary for starting productive academic faculty careers. Although this is not a new issue and may be similar for men and women, there are now some special factors that need to be taken into consideration. The duration of time before obtaining the first external award, particularly R-01 awards has, in general, become much longer. Further, many women, as well as some men, need specific assistance in determining the “what” and “how” of negotiating for the necessary resources to begin an academic career.

Responsible Organizations: Pediatric Chairs and Division Directors should take the lead in providing workshops on negotiating at the PAS and other national meetings as it is in their own interest that new faculty have the resources and protected time necessary to be academically successful. These workshops should include discussion of determining needed start-up resources, time for scholarly activities, moving and travel expenses, etc. It would also be helpful for AMSPDC to hold a workshop for Chairs and/or Division Directors on what are reasonable expectations for junior faculty obtaining external support, on what start-up resources are likely to be needed by faculty with various scholarly interests to have reasonable chances for “academic success,” and on appreciating possible gender differences in negotiating styles.

6. In all scientific disciplines, it is well documented that women are less likely to pursue research-intensive careers, including both laboratory and non-laboratory based disciplines. Pediatric Department Chairs and Division Directors should examine disincentives, specific obstacles and subtle environmental factors that influence the career choices of women trainees and junior faculty in their academic institutions. These factors may be lack of equivalent support in the early faculty years, a tendency of trainees to select programs directed by more senior and male faculty, and the possibility that young women and men react differently to the current long timeline to first extramural funding.

Since success in laboratory-based research and other fields of scholarship often requires access to Ph.D. trainees and an academic environment beyond that offered in departments of pediatrics, junior faculty should be supported for joint appointments in other departments. Junior women faculty may need particular guidance in establishing these connections.

The impact of childbearing on the options that women have and perceive themselves to have in the choice of research-intensive careers needs to be assessed and ameliorated within the environment of the particular academic institution, with pediatric leaders taking a visible and committed role in such efforts.

Responsible Organization: AMSPDC

7. Pediatric Department Chairs and Directors of Divisions should make information available about regional and national salaries and total compensation (provided by the AAP and AAMC) for various faculty ranks and subspecialties.

Responsible Organizations: Pediatric Department Chairs and Directors of Divisions within Pediatric departments.

E. Mid-level Academic Faculty

1. Pediatric Chairs and Division Directors

need to provide career advancement mentoring to mid-level faculty/associate professors to ameliorate lengthening times in rank. This issue disproportionately affects women faculty whose family responsibilities may limit travel to national meetings for presentations and participation in national committees resulting in limited opportunities for national visibility. This is a particular problem for those faculty who are not primarily involved in research-intensive careers. This mentoring should include an emphasis on the need to set career goals, focus scholarly activities, and the steps that need to be taken to achieve membership in the SPR, APS, and subspecialty organizations and participate in national and regional committees related to pediatrics.

Responsible Organizations: Department Chairs and Directors of Pediatric Divisions, AMSPDC, and AAP subspecialty sections.

2. Pediatric professional organizations should have more academically significant regionally based activities and strive to be more sensitive about family needs in establishing the timing of all meetings (e.g. avoid weekends and holidays).

Responsible Organizations: SPR, APS, APA, AAP, APPD, and Subspecialty Societies

3. National pediatric organizations, departments of pediatrics, medical schools, and teaching hospitals need to establish awards and endowed funds for faculty who have: a) substantially altered the professional environment locally and/or nationally to render it more family-friendly; and or b) have provided exceptional mentoring to enable substantial advancement of under-represented groups (including women and minorities) with regard to academic and administrative advancement. Such designated endowments may provide a unique opportunity for private donations.

Responsible Organizations: AMSPDC, APPD, AAP, APA, APS, SPR, AAMC

4. A survey should be undertaken of all departments of pediatrics to determine the gender and ethnic/racial representativeness in

leadership positions.

Responsible Organizations: AMSPDC, AAP

5. The AAP and the ABP should survey their staffs, committees, boards, and sub-boards to determine the gender and ethnic/racial representativeness in leadership positions.

Responsible Organizations: AAP, ABP

6. Mid-level faculty with potential for leadership positions often need additional support in acquiring management skills.

Responsible Organizations: AMSPDC should play a leadership role in organizing workshops on the financial management of academic units at the PAS and regional meetings of the AAP.

#### F. Senior Academic Faculty

There is need to accurately describe and assess the demographic trends of senior faculty in pediatrics and to consider the implications of these trends for junior faculty advancement, optional utilization of human resources, and changing gender composition of the faculty.

Responsible Organizations: The AAP Committee on the Pediatric Workforce should take a leadership role in providing such studies evaluating changing demographic trends, in cooperation with the AMSPDC and the ABP.

#### G. Private Practices of Pediatrics

Members of the Task Force on Women in Pediatrics did not think they could adequately analyze the issues related to women in the private practice of pediatrics without additional input from women who are currently in private practice in various settings. However, the Task Force recognized the importance of these issues and was aware that some of the issues were under consideration by groups within the AAP and the AMA. At this time, the Task Force recommends that the input from private practicing pediatricians be solicited by the AAP to identify issues that need attention and the specific measures that need to be taken to address problems that are identified.

The Task Force recognized that the issues that do need attention include but are not limited to the following: the impact of debt burden on entry and choice of practice setting; part-time employment; malpractice costs for part-time practice; contract negotiations for salary, hours, and partnership status; practice drop out rates; family friendly practice environments; advantages and disadvantages for women to practice within managed care organizations and possible practice groups of various sizes and compositions; income equity; roles in caring for underinsured and uninsured, subspecialty private practice; and the role of private practice hospitalists.

Responsible Organization: AAP

*The following is an abstract of the paper completed by the "COMSEP Survey Task Force." The majority of the work was compiled and then written by Christopher White from the Medical College of Georgia*

The 2004 COMSEP Survey: Preliminary Results

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**Objective:** The last survey of pediatric clerkship directors was published in 1995. We sought to provide an accurate, updated description of pediatric undergraduate medical education and pediatric clerkship directors (PCDs) in 2004.

**Methods:** A 106-item survey was designed by a committee from COMSEP (Council on Medical Student Education in Pediatrics) members and

administered via the Internet. Survey questions were written to update the 1995 survey as well as to address new issues in medical education.

**Results:** 110/131 (84%) of U.S. medical schools and 8/16 Canadian medical schools (50%) completed the survey. Significant differences compared with 1995 are shown in the Table:

	<u>1995</u>	<u>2004</u>
Length of time as a PCD	6.8 yrs.	7.5 yrs.
Women	24%	51.5%
Subspecialty training	66%	39%
Actual FTE allocated for clerkship activities	28%	40.4%
“Ideal” FTE for clerkship activities	36%	47.9%
Assistant Professor	22%	36%
Professor	34%	21%
Peer-reviewed publications (mean)	18.4	10.7

Ninety-one percent of PCDs expressed satisfaction with their jobs, and most felt that the position of PCD was a legitimate long-term career at their institution. More than two thirds of PCDs who had been promoted in the past 5 years felt that their position as clerkship director was influential in their being promoted. The average pediatric clerkship is 7.2 weeks, with approximately 50% of the experience occurring in either ambulatory or acute care settings. Forty-nine percent of students spend some time in a community practice setting. The COMSEP curriculum is used by 84% of responding pediatric programs.

**Conclusion:** Pediatric undergraduate medical education is perceived to be a legitimate career track but most PCDs hold lower academic rank and have less traditional scholarly activity than PCDs did 10 years ago. Pediatric clerkship directors feel that they should be allotted almost 50% of their time to adequately do their job.

### Task Force Reports

#### Faculty Development Task Force Report

*Submitted by Leslie Fall*

It was a highly productive meeting for the FDTF. With new leaders collaborating and fresh ideas from

new TF attendees as well as “seasoned” members in attendance, the setting was ripe for growth and expansion. Here are some of the highlights:

We began by better defining and identifying the purpose and responsibility of the FDTF. Motivated by this, a new mission statement was developed and approved. It reads as follows:

“The mission of the Faculty Development Task Force is to promote and encourage the academic advancement, scholarship, and professional development of medical student educators; and to support and enhance faculty as educators by developing and disseminating resources for medical education.”

The TF recognizes that we have always helped to provide ideas for workshops and encourage new content for workshops that are appropriate and meet the needs of all COMSEP members. In order to improve this structure we have created a Road Map for workshop curriculum that is based on all of the workshops previously presented over the past 12 years and goals for covering FD needs of the membership. Content and categories for the Road Map were accepted by the TF members and the Executive Committee and will be implemented for the upcoming meeting in SLC.

The FDTF began several new projects including development of a tool for workshop selection, recommendations for defining a workshop selection committee to be led by a FDTF member, and development of a method for workshop selection that is peer reviewed.

The FDTF is also working with the Research and Scholarship TF to create a tool for evaluating workshops. The TF determined that a two-step process would likely be most effective. First, utilizing the CME feedback for workshops, the selection committee may have data to consider for reviewing and choosing workshops. This feedback is not, however, the most effective for presenters. Thus, the FDTF plans to develop an evaluation tool for immediate feedback to presenters. While we do not wish to be redundant in our evaluations, the content will serve quite different purposes. The tool is being designed to offer productive, formative feedback to workshop presenters in order to better their own skills and FD for home institutions. We hope to make the new workshop evaluation tool available for all

presenters to use in SLC. It will be considered optional, but if useful, we will consider a means for collecting and reviewing these data among FDTF members, as well.

The mentoring program continues to flourish with Bill Wilson at the helm. Ideas were exchanged for continuing to build this program and improve the effectiveness of our mentoring/advising lunch. As we expand goals in this area, Michael Barone has agreed to join Bill in this effort.

Finally, we were very happy to have a new Journal Club senior editor volunteer. Thanks go out to Judith Rowen who stepped up to the plate. She is great example of a member who could share her expertise by asserting a desire to be involved. Given her editorial experience, she is a natural fit. We are excited to work with Judith on this project and keep it thriving.

There are lots of opportunities for members to become further involved with the FDTF. Reviewing articles for Journal Club, advising and mentoring new members, volunteering to be on a workshop selection committee or workshop evaluation committee are just a few ideas that have come out of our gathering in Greensboro. We are currently one of the smaller TF’s with lots of room for participation and leadership roles. Please let us know all that you are interested in seeing arise from this TF. As defined in our mission statement, this TF seeks to serve the advancement of our own members. Please help us to be successful in that endeavor.

### **Evaluation Task Force Report**

*Submitted by Paula Algranati*

The Evaluation Task Force met twice at the COMSEP 2005 meeting:

At our first meeting:

1. We reviewed the core competencies that should be evaluated for all medical students completing a basic pediatric clerkship. These were developed by the COMSEP Evaluation Task Force members at last year’s meeting and subsequently replicated (with consensus achieved in both venues) at the APA medical student education SIG. At the 2005 meeting, of the Evaluation Task Force, the group endorsed the previous endorsements of both groups (COMSEP



Evaluation Task Force 2004, APA SIG 2004).

CORE competencies to evaluate at the conclusion of the generic pediatric clerkship involve history taking, physical examination and information sharing:

History: Relevant to age/CC  
Universal data collection skills  
HPI/Health supervision visits  
PMH  
Growth  
Developmental assessment  
Nutritional status  
    Prevention/screening (including immunizations)  
Social history  
Including HEADSS  
    Household (including family violence predictions, substance abuse)  
Environment/personal safety (auto, bike, guns, smoking, lead, household)  
Family history  
Including a pedigree  
Physical Examination  
Vitals, Tanner, Hips (newborn/infants), Reflexes (newborn/infants), Fontanelles (newborn/infants), Eyes (RR), Ears, Extremities, Skin  
Recognize sick versus well  
    Developmental assessment (use checklists)  
Recognize and report child abuse  
Growth (measure, plot, interpret)  
  
Information Sharing  
Universal skills-rapport  
    Medications/prescriptions (age/wt prescriptions)  
    Verbal presentations  
    Write-ups  
    Inpatient admission orders  
Fluid therapy (oral/IV)  
    Anticipatory guidance (prevention/including immunizations)

2. The group also engaged in exercises to determine core medical knowledge competencies (core conditions that would be suitable for evaluation in medical knowledge, clinical decision making, focused topics suitable for evaluation of history taking and physical exam skills). The groups essentially came up

with two systems of categorizing core medical knowledge competencies (symptom-based and system based).

At our second meeting:

After reviewing the results of the exercise to determine core medical knowledge competencies and hearing the results of the parallel process of the curriculum task force, the group agreed to allow the COMSEP curriculum task force to determine what these areas of focus should include (core conditions). Thus, this task force would subsequently focus on evaluation of whatever the curriculum task force agreed upon.

The Evaluation Task Force did encourage/felt it was very important to include:

Clinical reasoning/medical knowledge re: illnesses unique to pediatrics AND especially to include the following areas beyond the symptom based/system based topics:  
Fever without focus in a young child  
Health supervision in newborns, children, and adolescents  
    Emergency problems  
Behavior and development  
Normal newborn issues

#### LCME NEW STANDARD DISCUSSIONS

The LCME will NOT tell you how many or what experiences you should require and THUS, we as an organization will also not tell you this. Rather, we will supply suggestions for components of your matrix and it is your responsibility to fill in the specific contents of the matrix as well as to fill in the #s.

In responding to LCME New standards, the group decided that a suggested matrix for clerkship directors would consist of the following:

(For specifics see above)

Experiences that would allow the opportunity for:

History taking  
Physical Examination  
Information sharing

(OR, alternative experiences such as simulated patient exercises such as CLIPP)

And that each clerkship director would enhance their

own matrix (specific to their own clerkships) the additional paradigms of:

Core conditions (to be specified by the COMSEP curriculum committee)

Ages/stages (newborn/infant, toddler/pre-school, School age, adolescent)

Acuity/Venue: acute problem focused, chronic problem, health supervision, emergency

And potentially another dimension would be: Student observed, student participated in care of student involved in CLIPP/other similar simulated patient exercise

The task force agreed that a minimum number of #1 per case/condition would be acceptable in the LCME new standard matrix but the specific decisions regarding items and numbers of encounters/conditions would be up to individual clerkship directors.

Suggestions for simulated patient exercises include:

#### CLIPP

Pedsedu.com (USUHS clerkship guidelines and forms)

Medcases (These mostly look as if they originate from Family Medicine, but a few may apply to pediatrics- please let us know if any of you have reviewed these cases and find these are helpful for our curriculum)

Interactive Pediatrics Oregon (I cannot find proper Web address for this- help please!)

Pedcases.org (Abuse & Neglect, Adolescent Mental Health, Adolescent Screening and Health Promotion, Adolescent Sexuality and Reproductive Health, Behavioral Pediatrics, Child Development, Collaboration Essentials, Growth in Children and Adolescents, School)

AAP (On-line Otitis Media Cases free)

Suggestions for alternative resources for evaluation tools/instructions regarding methodologies:

ACGME.org (Outcomes project... toolbox)

Mid-rotation “course corrections” to comply with LCME

Monitor via paper/handheld/web log-required by Dean’s policy

Mid-rotation evaluation done by course director, surrogate, site directors, students etc.

Consequences: Lower grade, professionalism citations, warnings, core reports with curriculum prescriptions (e.g., since you have not complete X, Y or Z, you must complete X, Y, Z in order to pass the rotation)

(Web logs from members willing to share/proprietary: BU, Dartmouth, others?)

OUR TASK FORCE GOALS FOR THE COMING MONTHS ARE:

1. Convey our support for the core competencies endorsed by the task force and AAP SIG to the Curriculum Task Force for inclusion in their recommendations.
2. Request that the Evaluation Task Force review the draft of the curriculum task force core competencies document (including the core conditions) for input, prior to distribution for endorsement to the general COMSEP membership
3. Once the revised COMSEP curriculum core competencies and core conditions (regarding knowledge/clinical decision making) are disseminated and approved, work on methods/instruments for evaluation of “meets expectations” performance levels of core competencies (AND, simultaneous with approval of the revised COMSEP core curriculum,  
*N.B.: Request from the general membership any/all methods or tools for evaluation of core competencies and core conditions. The ETF agrees to collect and collate these methods/instruments for documentation of minimum standards, and make these available to the general membership.*
4. Continued work on mid-rotation feedback (listing ideas, tools for useful methodologies)

*N.B.: Request from the general membership any/all methods/tools for mid-rotation feedback regarding progress towards achieving core competencies and complying with standards for LCME experiences.*

5. The next tasks for Evaluation Task Force members,

after making recommendations regarding methods/instruments for evaluation of “meets expectations” performance levels of core competencies, will be to explore strategies for evaluating/differentiating performance levels that exceed “meets expectations” (such as... near honors vs. honors etc.)

6. We also responded to the Technology Task Force requests for how they can help us and what we need to think about including on our portion of the web site. Eventually, we hope to include methods/tools for evaluation solicited from the general membership and categorize them according to how these relate to core competencies and core conditions.

### **Curriculum Task Force Report**

*Submitted by Bill Raszka*

The Curriculum Task Force (CTF) had a terrific meeting in Greensboro, North Carolina. We had a very large and lively group during a first meeting and more than 20 dedicated souls on Sunday morning. After discussion, the CTF agreed to work on two projects: 1) creating a template for the types of patients that should be seen during the clerkship experience and 2) reviewing the core competencies for each of the chapters in the core curriculum but paying particular attention to the chapter on common pediatric illnesses.

The rationale for creating a list of the patients medical students encounter during the clerkship is that many clerkships who have undergone LCME review recently have struggled with ED-2 which requires all clerkships define the type and number of patients that must be seen during a clerkship experience. Additionally, all clerkships must monitor whether students see the required patients and offer remediation or experiences if they have not seen the patients by a specific time in the clerkship (e.g. the midpoint). The CTF felt providing a framework of expected patient encounters for the clerkship would be of benefit for all clerkships preparing for LCME site visits (this sentiment was also stated by Frank Simon, the Secretary for the LCME). The CTF broke into groups to generate a list. The groups reported out and then by consensus, the final list was generated. On Sunday, the list was reviewed again and matched against the expected core competencies. The work will continue at the APA SIG as we hope to generate templates for potential use in the Pediatric Clerkships. The selected template will become part of the

curriculum as an appendix.

The rationale for revisiting the common pediatric illness chapter as that is the biggest chapter in the curriculum, most problematic to convert to a competency based curriculum, intrinsically difficult to structure around standards, and has implications for how to assess medical student skills and meeting LCME requirements. Again, teams broke into groups to look at the current curriculum and then came to consensus as to what were the core conditions or findings that students should either know about, generate differentials, or manage. This work will continue in the APA SIG meeting as we will take the list generated at the meeting and work with the templates from the Evaluation Task Force, make a grid of the core competencies and assessment strategies for each.

The CTF will be working closely with the ETF to complete these tasks. The goal is that by the end of May, we will have a National Core Pediatric Curriculum that is competency based, shorter in length, and provides a framework for integrating the curriculum within LCME, ACGME, and AAMC guidelines.

Addendum: The work was completed at the APA-SIG. The new version of the Pediatric Core Curriculum and a grid for meeting the requirements of the LCME have been posted on the COMSEP Web Page.

### **The Research and Scholarship Task Force Report**

*Submitted by Sherilyn Smith & Cindy Christy*

We had a wonderful group who engaged in lively discussions about current work and began focusing on the next year's tasks. There are several items that we will be working on, some of them in conjunction with other task forces. All activities are targeted to encourage the production scholarly works by COMSEP members and the recognition of these works within and outside of COMSEP. Our current projects include:

Improve the transparency and quality of peer review of scholarly materials within COMSEP.

**Rationale:** COMSEP members are a creative group of educators who produce high quality materials to instruct students. COMSEP provides a forum for sharing innovations and research that enrich and

motivate our membership. A broad definition of scholarship (Glassick et al) should be recognized by both members and their home institutions to help with the advancement of the members' academic careers. Key to any form of scholarship is the process of peer review and acceptance.

**Goals:** Our goal is provide evidence of peer review of all materials (workshops, posters, presentations) presented at COMSEP with the express purposes of improving the quality of members' work and facilitating the promotion of their academic career. The spirit of the peer measures is to be INCLUSIVE and provide FEEDBACK to our members.

**Activities:** We will be working with the Faculty Development and Learning Technology Task Forces to develop specific materials that will document the on-going peer review that occurs at COMSEP meetings. These new materials will be available for the next COMSEP meeting in Utah, 2006. In addition, we will be submitting abstracts from the 2005 COMSEP meeting for consideration to Teaching and Learning in Medicine. Some of these abstracts will appear as "Proceedings from the 2005 COMSEP meeting" in an upcoming issue.

Work to promote generation and sharing of scholarly works by COMSEP members.

**Rationale:** The generation of scholarly materials needs support...both financial and creative, both from colleagues and institutions.

**Projects:**

1. The executive committee has charged the research and scholarship task force for developing an application process for an award that will promote the advancement of our members' work. The award will be given in memory of Richard Sarkin and Steve Miller and will provide both recognition and monetary support for scholarly work performed by COMSEP members. We are in the process of developing an application process and anticipate the first award will be given at the 2006 COMSEP meeting.

2. A group is working on a **BRIEF** survey to assess COMSEP members' experience navigating LCME visits (especially with the clinical encounter requirement). Look for it in the early fall.

3. We had the first round of scholarship

consultations, performed by Larrie Greenberg (THANK YOU LARRIE!). We will be reviewing the outcomes and refining the process for next year.

4. We will be working with the Faculty Development working group to develop interesting workshops for next year's meeting about moving your scholarly work from ideas to reality.

**Learning Technology Task Force Report**

*Submitted by Mary Ottolini*

Since the theme of the 2006 annual meeting in Salt Lake City will be technology in learning, we began our annual task force meeting by sketching out plans for workshops. Workshop ideas included: the use of PDAs and wireless technology in teaching, both for education and for patient tracking; using asynchronous learning and patient simulations to supplement clinical teaching, and a large pre-meeting CLIPP workshop. A panel discussion was suggested to discuss how technology could be used to address the LCME requirements. A vendor technology display is planned, along with a poster symposium to demonstrate the use of innovative technology in action.

Our members also mentioned technology projects they are working on such as Robin Deterding's virtual reality simulation, and the Calibrated Peer Review Project sponsored by the National Science Foundation. This is a web-based program developed in New Mexico in which students set up a template to review and grade their own notes.

David Levine outlined how the website will be further developed to enhance communication and sharing of resources. The public pages will include announcements, task force reports, and an added tab for CLIPP; while the community pages will have a section available for both posting and sharing of educational resources. The Research Task Force will assist in determining a peer review process, based upon results of a survey done at COMSEP and collaboration with AAMC MedEdPortal is being considered.

Additional projects planned throughout the year are: establishing an online "technology consultation" collaboration where those in COMSEP with specific technology knowledge and experience can help novices. Chris Maloney volunteered to post

technology tips to the listserv every 1-2 months. Chris White will post “high yield” COMSEP survey results as they are available.

### COMSEP Journal Club

*Our sincerest thanks to Judy Rowen who kept this COMSEP activity alive and well. Judy was the senior editor for the Journal Club section with guest editorials by Robin Deterding.*

### Review by Lindsey Lane Jefferson Medical School

Dunaway G.A. Adaptation of team learning to an introductory graduate pharmacology course. *Teaching and Learning in Medicine* 2005;17(1):56-62  
Kelly A.P, Haidet P, Schneider V, et al. A comparison of in-class learner engagement across lecture, problem-based learning and team learning using the STROBE classroom observation tool. *Teaching and Learning in Medicine* 2005; 17(2): 112-118  
Michaelsen, L, and Richards B. Drawing conclusions from the Team-Learning literature in health-sciences education: A commentary. *Teaching and Learning in Medicine* 2005;17(1):85-88

Two articles about Team-Learning (and a commentary) in consecutive issues of *Teaching and Learning in Medicine* caught my eye and gave an opportunity to bring this teaching methodology to the attention of COMSEP members.

The article by Dunaway describes his experiences using his version (see below for explanation) of Team-Learning for a small – 9 students – graduate pharmacology course. The accompanying commentary by Michaelsen and Richards provides interesting insight into the Team-Learning process.

Team-Learning has been increasingly adopted as a teaching method in the health-sciences in the last 4-5 years: large classes (up to 200) are divided into teams of no less than 5-7 learners and are provided with learning objectives, guides, resources etc.; students engage in self-directed learning; take individual readiness assurance test (RAST); each team practices solving problems using scratch off cards (like lottery tickets) that reveal correct answers – the Immediate Feedback Assessment Technique or IF-AT; and then each team solves problems/ assignments in class. There is a “3S’s rule” for the class problem solving

assignments: all teams solve the Same problem; each team makes a Specific choice of best answer (like an MCQ question); and each team Simultaneously reports the answer. Following presentation of team answers “constructive controversy” ensues moderated by the teacher who must be a content expert. Members of a team each receive the same grade based on correct answers to IF-ATs and class problem solving. There is also peer evaluation of each student by fellow team members. The RAST ensures that all students have a basic knowledge level and the “team/peer” evaluation ensures that no students are “loafers” who allow others to do the work!

Proponents of Team-Learning outline the educational advantages as 1) Promotes self-directed learning, 2) Increases individual participation, 3) Promotes teamwork, 4) Promotes problem solving and 5) Goals 1-4 can be achieved with a single teacher/faculty member. These educational advantages, with the exception of #5 are the same described for Problem Based Learning (PBL), however PBL requires individual leaders for each small group (a class of 200 would require approx. 20 faculty).

Dunaway’s method deviates from “classic” Team-Learning by having small teams of 3 students – maybe not enough intellectual capacity to problem solve effectively; by not having RASTS; by having the instructor deduct points if he felt a student was “slacking”; by using in-class lectures to present material; by having teams solve different problems; and by having teams present in narrative form sequentially. Despite this Dunaway’s students reported that they enjoyed and felt the experience was educationally valuable by increasing their classroom involvement, preparation prior to class and insight into the material. However, on the only objective measure of student performance – a knowledge test- the grades were similar to other classes.

The conclusion to be drawn here is that, like PBL, not all Team-Learning is really Team-Learning! This means that care must be taken when interpreting outcomes reported in the literature. In addition we also have to recognize that teacher and student self-report of “outcomes” have poor reliability and validity compared to outcomes that objectively measure student behavior and performance.

The article in the next issue of TL&M by Kelly et al is last authored by Boyd Richards who is co-author of the commentary on Dunaway’s article.

This article takes as its premise the theory that “active” learning provides advantages over “passive” learning. In active learning it is postulated, “a variety of cognitive processes and verbal and non-verbal behaviors occur simultaneously” leading to “increased assimilation and retention of content and concepts.” As a marker for “active” learning the authors measured in-class learner engagement: learner with learner and learner with instructor during Team-Learning, PBL and traditional lecture.

Data were based on observations using the “strobe method” in which repeated 5-minute observations of “engagement” are made every 8-10 minutes during a class. Each 5-minute observation period consists of four 10-20 second observations of individual learners, overall class observation, instructor observation and a count of the number of questions asked by the instructor and the students. It is not surprising that the authors found that engagement in lecture was predominantly learner-instructor; in PBL learner-learner; and in Team-Learning was more balanced between the two. Although the authors refrain from drawing conclusions as to what type of engagement is “better” for students’ learning they do point out that many faculty find PBL a difficult teaching method as they are unable to deliver didactic material or act as content experts. In contrast, Team-learning allows faculty to “teach” and may have a “broader appeal” for instructors.

At my institution, Jefferson Medical College, Team-Learning has been introduced in the microbiology course and is highly rated as a teaching/learning method; student grades on microbiology tests remain the same but we do not (yet) have any objective measures of student behavior or performance. Team Learning is certainly an educational area where more research needs to be done; are other schools using Team-Learning and do any COMSEP members have objective educational outcomes from this teaching method to share?

*Lindsey’s review provides an important look at a “hot” and emerging educational process to deliver curriculum. What methods would you prefer as a learner – lecture, PBL, or team-based learning? Is your school using team-based learning in the clinical years? Could you use it in your clerkship? - Robin*

#### **Review by Norm Berman**

#### **Dartmouth Medical School**

Cook, D. (2005). The Research We Still Are Not Doing: An Agenda for the Study of Computer-Based Learning. *Acad Med*, 80(6), 541-548.

Abstract: In 1994 Friedman published a paper, about computer-assisted instruction (CAI) research titled “The Research We Should Be Doing.”<sup>1</sup> In this brief but seminal paper Friedman explained some of the difficulties inherent in performing media-comparative studies of CAI programs. He then went on to propose a CAI research agenda in which studies “might explicitly contrast different approaches to the design of computer-based instruction.” Unfortunately, although this paper is often referenced, the majority of the published CAI literature today is comprised of media-comparative studies, which compare CAI to other teaching methods.

The current paper by Cook is meant to readdress the issue that was not solved by Friedman’s paper. Cook explores confounding in media-comparative research and, using concepts promoted by Geoff Norman, he discusses the importance of a tightly controlled setting and that the various factors that contribute to a result are systematically varied based on a theory of causation. Savvy readers may recognize this as the scientific method!

Cook then proposes a framework for future studies that views all instructional design, in computer-based learning or other methods, as having 4 levels – medium, configuration, instructional method and presentation. Medium, as suggested by the term media-comparative studies, is the level where computer-assisted instruction is compared to other media such as books or lectures, a level at which meaningful comparison is not possible. Configuration refers to the differences within a given media format, such as CD-ROM vs. web, or synchronous vs. asynchronous learning. Instructional method refers to the teaching techniques that support a learning process, such as case-based or problem-based learning or the use of simulators. Finally, presentation refers to the elements of the medium that enhance the intervention, such as multimedia, use of hyperlinks and the use of interactive questioning. Cook suggests that to avoid confounding, research is best done within rather than between levels.

Finally, Cook discusses some possible themes and outcomes for research including adaptation to

individual difference, just-in-time learning, simulation and integration. Importantly, there is recognition of the value of rigorous qualitative studies in CAI research.

Review: Cook effectively reiterates the message of Friedman's classic paper, and then goes on to propose a valuable new framework for future research on CAI. This paper should be required reading for anyone interested in pursuing research related to computer-assisted instruction. As COMSEP moves forward in CAI research, this article will be very helpful in focusing our efforts appropriately.

1. Friedman, C. (1994). The research we should be doing. *Acad Med*, 69(6), 455-457.

Norm provides a great review of an area that is becoming increasingly more important in all areas of education. As some of you know I have been getting my Masters of Health Professional Education (MHPE) on-line and it has been quite eye opening about what type of a student I am on-line and with CAI. Have you ever participated as a learner with CAI? If not you should give it a try sometime from the learner's perspective.

*Have you tried to think about ways to research computer assisted instruction (CAI)? Would data about these different elements of CAI influence your use of this material? –Robin*

**Review by Sherilyn Smith**  
**Univ. of Washington School of Medicine**

Barbour, RS. Making sense of focus groups. *Med Edu* 2005 (available electronically).

This article is a good introduction on how to use focus groups in medical education. It is easy to read and hits the most important points to consider if you will be using focus groups. The author highlights potential uses of focus groups in medical education such as use in the initial phase of a survey design, curriculum review or exploring topics that are not easily quantifiable (e.g. professionalism). She then discusses how to choose participants for focus groups, how you can compare between focus groups and touches on some practical issues. The final section briefly mentions analysis of her findings, but mainly sights general quantitative methods with out

exploring "pitfalls" in analysis of materials from focus groups. It is a must read for someone with no experience because it will cause you to pause before you launch into a project that was not completely well thought out (always a good thing). If you have already successfully conducted focus groups, you probably won't learn too much from this article. It is well referenced and is useful for background reading about methods.

*Do you use focus group data to look at your clerkship? Have you participated in a focus group on anything – politics, movie review, etc.?- Robin*

**Review by Elizabeth Stuart**  
**Stanford University**

Halbach J, Sullivan L Teaching Medical Students About Medical Errors and Patient Safety: Evaluation of a Required Curriculum, *Academic Medicine* 80(6): 600-6

Halbach and Sullivan report on a required patient safety curriculum at the New York Medical College in Valhalla. 572 students participated over 3 years.

The curriculum was intended to raise students' awareness of medical errors and to provide practice with communicating errors to patients and families. The centerpiece of the program was a videotaped simulation: each student disclosed an error to a standardized patient and received feedback from patient, peers, and faculty.

Students completed a brief questionnaire before and after participating in the curriculum. Questionnaire items assessed students' awareness of the frequency and impact of medical errors, the likelihood of committing errors themselves, and their own strengths and weaknesses in interviewing patients and communicating about errors. Participants also completed a written evaluation of the curriculum itself and a follow-up questionnaire 2-8 months after the end of the program.

There were significant improvements on all items of the pre-post curriculum questionnaire. Students' responses on the program evaluation survey indicated that the majority found the curriculum and the SP exercise helpful. Of those who responded to the follow-up questionnaire, most reported an increased

awareness of medical errors weeks to months after the end of the curriculum.

**Comments:**

This paper deserves a catchier title. Based on my own experiences with patient safety education, I expected to read about a curriculum emphasizing prevention and avoidance of medical errors. This program took a happily surprising approach: acknowledging the reality of errors and preparing students to deal with them on an interpersonal level. A few features are worth highlighting:

During the SP exercise, the task of discussing an error with a patient included four key skills: apologizing for the error, taking responsibility for the error, admitting not knowing something, and making attempts to reestablish trust. These are crucial skills with applications far beyond disclosing errors to patients. (They would work well as specific learning objectives or competencies for broader training in professionalism.)

In their introduction, the authors mention “the hidden curriculum” and the need to address emotional and professional cultural barriers to discussing medical errors. The involvement of faculty role models that were willing to openly reflect on their own errors takes an important step in the right direction.

Overall, I found the content of this curriculum intriguing. The evaluation seemed too limited to capture the full impact of the program and would have been strengthened by the inclusion of a control group, outcome measures other than self-reported attitudes, and a qualitative assessment of students’ reactions to the program. Still, the paper offers useful ideas for teaching about patient safety and beyond.

*Medical errors and patient safety are other important and “hot” topic areas. How many of you have had to admit errors with patients? Is this a resident or student level skill? How should learners use these skills on the inpatient team with an attending responsible for the patient or when others on the team have committed the error? – Robin*

**Review by Randy Rockney  
Brown Medical School**

Bickel J, Brown AJ. Generation X: Implications for

Faculty Recruitment and Development in Academic Health Centers. *Acad Med* 2005; 80(3):205-210.

AND

Howell LP, Servis G, Bonham A. Multigenerational Challenges in Academic Medicine: UC Davis’s Responses. *Acad Med* 2005; 80 (6):527-532.

Bickel and Brown note that the largest generation ever, the Baby Boomers (born between 1944 and 1964 or 1945 and 1961, depending on the source), currently occupy most department head and senior leadership faculty positions and will soon be retiring. Their roles will need to be filled by the next generation, Generation X (1964-1984 or 1963-1981), current junior faculty and residents, a generation that is both numerically smaller and seemingly less attracted to academic careers. This transition, therefore, will likely lead to understaffed academic departments whose faculty members will experience greater levels of stress and frustration because they will be called upon to cover inadequately staffed clinical practices and be less productive. To remedy this problem faculty recruitment, retention, and development efforts must acknowledge and respond to differences between generations.

A “generation” refers to a group that “came along at the same time” and is shaped by the social, political, and economic trends prevalent at those times. The Baby Boomers experienced prosperity, two parent families, a TV in every house, the Viet Nam War, the Civil Rights Movement, the assassinations of the Kennedys and Martin Luther King, the Cold War, increasing opportunities for women, greater availability of birth control, and more. Members of Generation X were twice as likely to experience parental divorce and therefore live with one parent or come from dual career parents who may have experienced downsizing by the corporation for whom they worked. They could often be described as latchkey kids, had the first personal computers, and needed to be always conscious of AIDS. In consequence, the approach to work and career differs between the two generations. Members of Generation X work hard if balance is allowed; expect many job searches; don’t consider “paying dues” relevant; are less enthusiastic about self-sacrifice; and question authority. Baby Boomers in contrast work hard out of loyalty; expect long-term job security; pay dues; look on self-sacrifice as a virtue; and respect authority. That work related conflicts arise should be no surprise.

Academic departments should ask the question, “How



cross-generationally friendly are we?" A number of ideas about how to do just that are offered by Bickel and Brown as well as Howell, Servis, and Bonham who describe how multigenerational challenges are addressed at the University of California, Davis, School of Medicine.

One such challenge concerns workloads, working hours, and compensation. Generation Xers perceive that their parents' self-sacrifice and loyalty to their employers often had a negative impact on marriage and health. They look at Baby Boomers and say to themselves, "I don't want to end up like him [or her]." Boomers themselves are taking the cue from Generation X and setting more boundaries on their own work [I know I do]. Howell et. al., note an ongoing trend of decreasing attendance by residents at educational sessions and junior faculty at orientation and faculty development programs. Generation Xers wonder if attendance at so many meetings is even necessary? Over a third of Generation Xers say they would rather go to the dentist than attend an orientation program. Residents at my program once told me that they would have to be pre-medicated before they would attend a sensitivity training session [sensitivity about what I can't remember]. Institutions, like UC Davis, can respond by scheduling meetings during regular working hours and not evenings and weekends. Scheduling meetings during working hours, however, erodes clinical income and is not popular with department chairs causing this to be an ongoing challenge at UC Davis.

Boomers, like their predecessors, the Silent or, according to Tom Brokaw, the Greatest Generation, by and large, have not objected to doing twice the work he or she was paid for. Generation X does not see this as a reasonable expectation. One response, again challenging to existing resources, is for compensation plans to provide rewards for "overtime" or call. The issue of "Face time," time actually physically present at work, can also be a source of conflict between the generations. Generation Xers posit that "face time" need not be the sole measure of commitment to work, giving faculty more flexibility to attend to family or personal needs, and instead using productivity as a measure of effort. Also, increased use of technology may allow for the creation of a more flexible work environment.

Another challenge is recruitment and retention of faculty. It costs 1.5 times the first year's salary to

recruit and train a new or replacement faculty member, and there are hidden costs as well such as the overload on other faculty until a new person is found. Strategies to aid retention include allowances for more work-life balance and flexibility through part-time employment, generous family leave, and non-traditional career paths. Important too is more attention to thoughtful mentoring, mentoring that takes into account the generational differences in attitudes toward professional life. Another strategy is to provide more faculty development options that specifically focus on career planning and development. Important, too, is leadership, having forward looking department chairs who are attentive to stalled careers, morale issues, and the need for trust and constant communication.

Both articles conclude with exhortations to update faculty recruitment and development strategies to allow multigenerational teams to function more effectively and creatively in education, research, and clinical care; and to attract and nurture the next generation of faculty at academic medical centers.

Comment: When I first heard of this discussion at an Internal Medicine Grand Rounds about a year ago, I was very intrigued by the concept of the generations being shaped by the shared sentinel events in their lives and how the different outcomes caused explainable conflicts between generations in the medical workplace. Upon reflection, though, I wondered if a lot of it was mere pop psychology based on a number of over generalizations. True, I thought, at an age when I spent a lot of time seeking hedonistic gratifications of various sorts, my father, a member of the Silent generation, was flying 35 missions over Japan in a B-29 knowing that if he survived a plane crash he would likely be beheaded by the locals. That and his having grown up during the depression while I lacked for nothing must have affected each of our attitudes toward work and life. On the other hand, while I am a member of the baby boom generation, my outlook is just as likely to be akin to that of the generation Xers as it is to that of my fellow boomers, a likelihood acknowledged by Bickel and Brown. As a resident in the early 1980's I wore a button on my white coat that read, "Question Authority." [Actually, in the interests of full disclosure, the first word wasn't "Question," and I usually took it off in the presence of families and senior faculty.] My reservations aside, no one can argue against most of the accommodations and improvements in the work place—promotion of

work-life balance, compensation for effort and achievement, greater work environment flexibility-- that consciousness of differences between generations is promoting.

*Randy provided a wonderful review, very worthy of pondering. Do you see generational divides and is there constructive conversation about these issues in your academic environment? With what qualities in each generation do you relate and how does it impact your view of learners and faculty? What will the next generation look like? – Robin*

**Enhancing the Clerkship with Technology**  
**March 16-19, 2006**  
**Hilton Salt Lake City Center, Salt Lake City, Utah**

Wednesday, March 15, 2006

1:00 pm – 5:00 pm Registration

Thursday, March 16, 2006

7:30 am - 5:00 pm Registration  
8:30 am - 12:30 pm Pre-Conference Workshop: Leading the Clerkship in Pediatrics: A Workshop  
for New Clerkship Directors  
9:00 am -12:30 pm Executive Committee Meeting  
12:30 pm - 1:30 pm Reception/Light Lunch for New members, Identified Mentors, and Executive Committee  
2:00 pm - 3:30 pm General Session  
Welcome and Meeting Overview - Chris Maloney, MD  
COMSEP Updates – Robin Deterding, MD  
Task Force Reports  
President’s Address – Robin Deterding, MD  
3:30 pm - 3:45 pm Break  
3:45 pm - 5:45 pm Task Force Meetings  
Learning Technology, Evaluation, Curriculum, Research, Faculty Development  
6:00 pm - 9:00 pm Hospitality Suite Available for Members to gather, socialize, and make dinner plans  
6:30 pm - 10:00 pm PUPDOCC Dinner Meeting (Canadian Clerkship Directors)

Friday, March 17, 2006

Registration  
7:30 am - 8:00 am Continental Breakfast  
8:00 am - 10:00 am COMSEP General Session  
*COMSEP Business Items – Robin Deterding, MD*  
Miller/Sarkin Invited Lectureship Speaker: Suzanne Stensaas, PhD – University of Utah  
10:00 am - 10:15 am Break  
10:15 am - 12:15 pm Choice of Workshops A1-A7 (Choose One)  
12:15 pm - 1:30 pm Lunch with the Experts  
1:45 pm - 3:15 pm Choice of Workshops B1-B7 (Choose One)  
3:30 pm - 6:00 pm Free time - (Poster Presenters to set up posters during this time)  
Hospitality Suite available during this time for members to gather, socialize, and make dinner plans  
4:00 pm - 5:30 pm Depart for Optional 1 hour Hike to Red Butte Gardens  
6:00 pm - 7:30 pm COMSEP Poster Presentations and Reception

Saturday, March 18, 2006

Registration  
7:30 am - 9:00 am Continental Breakfast  
9:00 am - 11:00 am Workshops C1-C7 (Choose One)  
11:15 am -1:15 pm Research Presentations with boxed lunch  
1:30 pm - 3:00 pm Task Force Meetings  
3:00 pm - 3:30 pm General Session Wrap-Up  
3:30 pm - 4:30 pm New Clerkship Directors Wrap-Up  
3:30 pm - 4:30 pm Executive Committee Meeting  
6:45 pm Buses depart for Memorial House  
7:00 pm - 9:30 pm Closing Dinner at Memorial House, Downtown Salt Lake City  
10:00 pm Adjourn!

Sunday, March 19, 2006

Departures

*Program subject to change.*

**DON'T FORGET THE DATES OF THE 2006 COMSEP MEETING  
March 16-18, 2006 - Hilton Salt Lake City Center, Salt Lake City, Utah.**



If you do not receive the annual meeting material by USPS, please contact Lisa Elliott at [lelliott@abpeds.org](mailto:lelliott@abpeds.org)

