The Pediatric Educator

Council on Medical Student Education in Pediatrics

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Message from the President

Halloween is over, the cold rain and wind have arrived in Iowa, and Thanksgiving a few days away. *Even more importantly*, the COMSEP annual meeting in Indianapolis will take place March 22-24, 2012! Mitch Harris and Indiana University have planned a great meeting! We will have a full schedule of workshops, research presentations, and Task Force meetings, and we will celebrate our 20th anniversary at the Indianapolis Children's Museum with a dinner and dancing. Everyone who attends will have the opportunity to catch up with friends, make new acquaintances, and engage in networking. Calls are already out for workshops and abstracts for platform and poster presentations. Look on the COMSEP website for the links. Meeting registration will open after the New Year.

Since my last message for the *Pediatric Educator*, I and the rest of the Executive Committee have been working to advance the goals set in our strategic plan from November 2010. The Executive Committee met for its fall meeting on September 10 and 11 in Arlington, Virginia, immediately following the PEEAC-2 meeting (more about PEEAC later).

- Membership and voting rights were discussed and the bylaws were revised to reflect changes that have taken place in the organization. The bylaws changes will be submitted to the membership for vote in January 2012.

- Mike Barone and Susan Bannister presented a proposal to develop a COMSEP Awards Program. The program has three goals:
  - To ensure COMSEP members are aware of national awards that they may be eligible for.
  - To make COMSEP members aware of prestigious institutional or national awards that have recently been awarded to COMSEP members.
  - To accept nominations and distribute COMSEP awards to current and past COMSEP members at the COMSEP annual meeting.

  As part of the new Awards Program, COMSEP will soon issue a call for nominations for the following COMSEP Awards:
  - Teaching / Education
  - Research / Scholarship
  - Excellence in Clerkship Administration
  - The COMSEP Achievement Award

  You can find more information on submitting an award at http://www.comsep.org/awards12/. Deadline for nominations will be January 6, 2012. Awards will be presented at the 20th Anniversary meeting in Indianapolis.
- A new Executive Committee position, Treasurer, was agreed upon at the November 2010 strategic planning session. Bill Raszka was appointed as the interim-Treasurer for Fiscal Year 2011. COMSEP members will have the opportunity to choose among candidates for Treasurer on the January 2012 ballot.
- The Executive Committee has sent a letter to the Federation of Pediatric Organizations (FOPO) requesting that COMSEP be invited to present its perspective on medical education when the 7 organizations that make up FOPO ([AAP, ABP, AMSPDC, APA, APPD, APS, and SPR] meet to discuss topics pertinent to COMSEP. Because COMSEP is not an independent organization, we are represented in FOPO by AMSPDC. COMSEP's role in medical education has grown exponentially since its founding in 1992. COMSEP leaders believe that now is the time to make our voice heard as FOPO enters into discussions about Pediatric workforce and the education needed to produce the pediatricians of the future.

PEEAC-2 was held September 9th and 10th in Arlington, Virginia, co-sponsored by COMSEP, APA, APPD, and CoPS. By all measures, the meeting was a huge success. Registration was completely "sold out" weeks before the actual date. Participants uniformly praised the format and content of the meeting. The workshops engaged faculty from all 4 sponsoring organizations and focused on teaching strategies, evaluation, assessment and feedback, curriculum development, and educational scholarship. A poster session was added for PEEAC-2 and provided the opportunity for participants to present research, educational advances, and programmatic changes at all levels of pediatric education. For many attendees, this was the highlight of the meeting. A conference call to begin making plans for PEEAC-3 will be held the next month or two. I plan to represent COMSEP in this planning process, at least initially. The presentations and handouts are now available in the members' only section of the COMSEP website!

I was invited by Benard Dreyer, President of APA, to represent COMSEP at the APA strategic planning meeting on October 27 in San Francisco. Building on the collaboration involved with development and implementation of PEEAC-2, this meeting presented the opportunity to expand COMSEP's collaboration with an organization long involved with pediatric education. COMSEP evolved from the APA Medical Student Education SIG, and we continue to present that SIG at the APA annual meeting. In addition, the APA education committee and the APA task forces are all interested in establishing collaborative relationships with COMSEP. Plans are now in process to engage members of our two organizations in further collaboration.

On October 28, after a "red eye" flight from San Francisco to Philadelphia, I attended the Executive Committee meeting of AMSPDC to make the yearly presentation about our organization's activities. I provided a report that documented the progress that COMSEP has made towards its strategic goals and emphasized the educational and scholarly activities of our members. We had a very positive discussion about our plans to make changes to the bylaws, hold twice-yearly executive committee meetings, develop a COMSEP awards program, and upgrade the website.

You will soon learn about a new project to develop a curriculum devoted to clinical reasoning. Elizabeth Stuart has taken the lead to develop this project that will be shared among all COMSEP task forces. The leadership of APPD and APA has expressed interest in joint work on this project.

REMEMBER:

EDUCATIONAL GRANTS PROGRAM: Once again, please consider submitting an educational grant proposal for funding by the COMSEP Grants program. Information can be found at http://www.comsep.org/ScholarlyActivities/Grants_Program.htm. All applications are being accepted online. The deadline for submitting an application is December 6, 2011 at 5 PM EST.

ANNUAL SURVEY: You should have already received a link to the survey and a Username and password. Please contact the Executive office at info@comsep.org if you did not receive your survey login information.

2012 ANNUAL MEETING WORKSHOPS: The deadline to submit your workshop abstract for the 2012 annual meeting is quickly approaching. Be sure to visit http://www.comsep.org/abstract12/ by November 20th for more information and to submit your abstract!

2012 ANNUAL MEETING POSTER/PLATFORM PRESENTATIONS: The deadline to submit your poster/platform presentation abstract for the 2012 annual meeting is December 21, 2011! Be sure to visit http://www.comsep.org/abstract12b/index.cfm for more information and to submit your abstract!

Please accept my best wishes for the upcoming holidays. I'll see you in Indy!

Jerry Woodhead
jerold-woodhead@uiowa.edu

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Calendar Item	Deadline / Dates	Additional info / website
2012 Call for Proposals to Advance Scholarship in COMSEP	Deadline: Tuesday, December 6, 2011	***Grant Proposal System Now Open!*** For more information and to submit your proposal: *www.comsep.org/ScholarlyActivities/Grants_Program.htm*
2012 COMSEP Annual Survey	Deadline: Saturday, December 31, 2011	***COMSEP Annual Survey Now Open!*** Annual Survey login information was distributed to all active members on October 14, 2011
2012 Annual Meeting Workshop Abstract Entry System	Deadline: Sunday, November 20, 2011	***2012 Annual Meeting Workshop Abstract Entry System Now Open!*** Visit http://www.comsep.org/abstract12/ for more information and to submit your abstract!
2012 Annual Meeting Poster/Platform Abstract Entry System	Deadline: Wednesday, December 21, 2011	***2012 Annual Meeting Poster/Platform Presentation Abstract Entry System Now Open!*** Visit http://www.comsep.org/abstract12b/index.cfm for more information and to submit your abstract!
2012 COMSEP Awards Nomination Entry	Deadline: Friday, January 6, 2012	***2012 COMSEP Awards Nomination Entry Now Open!*** Visit http://www.comsep.org/awards12/ for more information and to submit your nomination!
2012 Annual Meeting - JW Marriott Indianapolis, Indianapolis, IN	March 22-24, 2012	Additional information will be distributed via listserv and posted on the COMSEP website as it becomes available.

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COMSEP Task Force Updates

Curriculum Task Force

Submitted by:
Sandy Sanguino ssanguino@northwestern.edu
Elizabeth Stuart aestuart@stanford.edu
Greg Toussaint gregory.toussaint@wright.edu

The Curriculum Task Force has been working on 4 key projects:

1. Core Curriculum: Needs Assessment
   A subgroup of the Task Force has submitted a handful of needs assessment questions to be considered for inclusion in the COMSEP Annual Survey. Our goal is to determine whether and how to refine the core clerkship curriculum to meet the changing needs of clerkships.

2. Core Curriculum: Common Problem Sets
   The Common Problem Sets subgroup has been very active since we met in San Diego, creating user's guides to go with the Common Problem Sets that are included with the core clerkship curriculum. The group plans to post all completed user's guides on the COMSEP website.

3. Sub-internship Curriculum: Learning Activities
   Check out the newly posted Sub-I Learning Activities in the Members Only section of the COMSEP website! (Go to Member Files -- Curriculum Materials -- Pediatric Subinternship Curriculum -- Learning Activities) The Learning Activities take the form of interactive cases for discussion or simulation, with links to the competencies and objectives in the Sub-I curriculum. Topics include Failure to Thrive, Fluids and Electrolytes, Altered Mental Status, Abdominal Pain, and Respiratory Distress. There is a general facilitator's guide to with the cases as well as a form to provide feedback.

4. Clinical Reasoning Collaborative
   In San Diego, we generated initial ideas for a curriculum to promote deliberate practice in clinical reasoning, which led to plans to form a multi-Task Force Clinical Reasoning Collaborative. Since then, the scope of the project has expanded! We now hope to work not only with all of the COMSEP Task Forces, but also with the APA Medical Student Education SIG, APA Education Committee, and APPD. To kick off the new Collaborative, our first project will be to create an informal resource library of strategies to promote and assess clinical reasoning. The project will have two major goals. One is to enable informal sharing of ready-to-use teaching, assessment, and faculty development tools. The other is to provide support and collaboration for those interested in pursuing further development and formal dissemination of educational materials. Keep an eye out for a Call for Submissions survey, to be distributed when COMSEP meeting registration opens.

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Evaluation Task Force

Submitted by:
Gwen McIntosh gkmcinto@wisc.edu
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Lisa Martin limartin@lumc.edu

We are pleased to welcome Lisa Martin to the leadership of the Evaluation Task Force (ETF)! At the 2011 Annual COMSEP meeting the Evaluation Task Force accomplished four main goals:

1. The ETF recently completed outlining the minimal acceptable level of skills needed for students to demonstrate competency. The document corresponds to the COMSEP Curriculum and may be useful for developing clerkship experiences and evaluations such as OSCEs (Objective Structured Clinical Examination). The link to the document will be posted on the COMSEP website at the Evaluation Task

Force page and the Curriculum page.

2. Defining future directions: We reviewed results of the group's needs assessment questions included in the COMSEP Annual Survey. Through consensus we determined future work of the committee should be a) to continue to develop workshops that target different aspects of evaluation while focusing on the essential principles of successful evaluation for submission to each COMSEP annual meeting and other venues such as APPD, APA, AAP and PEEAC meetings; and b) to explore further the concept of medical student peer to peer assessment (see item 4).

3. Workshop development: A subgroup spent the majority of the remaining task force time further developing a COMSEP workshop submission on the comparability of student assessment across clerkship sites.

4. Next steps in medical student peer to peer assessment:

   a. A subgroup will perform a systematic review of the literature related to medical student peer assessment, which will further inform project development.
   b. Based on the literature view, a subgroup will begin to develop a multicenter study to describe and evaluate a peer assessment tool. Development of the multicenter study will be a part of the Evaluation Task Force sessions at the 2012 annual meeting.

This year would be a great year to get involved with the ETF as we are setting the groundwork for the next several years of Task Force initiatives. We anticipate opportunities both for seasoned ETF veterans and for willing newcomers!

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Research and Scholarship Task Force

Submitted by:
Jan Hanson jhanson874@verizon.net
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Robin English rengli@lsuhsc.edu

The RSTF had more attendees at our meetings this year than ever before, and we were thrilled at the level of enthusiasm that attendees brought with them. The peer-review process for abstracts that was developed at last year's meeting was deemed a success due to the convenient on-line submission format and a user-friendly scoring rubric based on Glassick's criteria for high quality educational scholarship. Members of our task force reviewed 40 abstracts for the 2011 meeting – of these 35 were selected as posters, and 4 were presented as platform presentations. Our poster session was also thought to be successful, although we all would have liked a little more time to share our scholarly projects with one another. Congratulations to all who presented, as well as to those whose posters won the awards for best scholarship. The winners this year were:

i. Lisa Leggio MD, Leila Stallworth MD, Valera Hudson MD. Advanced Pediatrics: Innovative Elective Prepares Students for Senior Year and Pediatric Residency
ii. Jennifer Soep MD, Matthew Vitaska ND, RN, Wendy Madigosky MD, Daniel Hyman MD. Innovative Interprofessional Quality Improvement Curriculum
iii. Robert Greenberg MD (new member), Jennifer Trainor MD, Melissa Brannen MD, Julie Stamos MD. High-Fidelity Infant Simulation and Debriefing in a Pediatric Clerkship
iv. Melissa Held MD, Cynthia Christie MD, Eve Colson MD. Barriers to Assessing and Remediating Professionalism : A Survey of Pediatric Clerkship Directors

We plan to develop an Abstract Subcommittee next year so that we can continue to improve the abstract submission and review process.

Our task force presented 2 workshops at the San Diego meeting, and they were both well received. Many

thanks to Jean Petershack and Mary Rocha for their leadership on these workshops, as well as to the many task force members who participated. Next year we hope to offer other workshops to help COMSEP members better understand quantitative methods and qualitative research.

Data analysis is underway for the Multi-Institutional Study of Curriculum Objectives, Individual Learning Plans and Student Learning in the Pediatric Subinternship, a joint project of the leaders of the Research and Scholarship Task Force and Curriculum Task Force. To date, we have 12 participating schools and have collected over 50 student ILPs. We are hoping to present results at next year's COMSEP meeting.

One of our upcoming projects for the year is the Clinical Reasoning Project. This project looks to be quite involved and will therefore require the minds and dedication of many COMSEP members. TJ Jirasevijinda is taking the lead for our task force and is already working with the leaders of the Curriculum Task Force to move the project ahead. Sherilyn Smith and other members of our task force are also looking at outcomes of projects that have been presented at COMSEP meetings in the past. She has solicited your input, so if you have presented at past meetings but have not responded, please let her know whether you were able to further disseminate your project in other venues.

Thanks to all of you who participated in our meetings this year. Our task force is definitely growing, and there is exciting work ahead! We will be contacting you in the next few months to start planning for workshop submissions for the Indianapolis meeting and to keep moving on other projects.

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2012 Annual Meeting Preview

Submitted by:
Mitch Harris mharris@iupui.edu

Mindfulness in Medicine
Indianapolis, IN

Indianapolis is eagerly looking forward to COMSEP 2012, our 20th birthday! Our meeting dates are March 22-24, 2012 at the JW Marriott in downtown Indianapolis. Our theme is Mindfulness in Medicine with Tom Inui as our keynote speaker. We will have a wide variety of preconference workshops including the Indiana University Relationship Centered Care Initiative faculty on working with reflective narratives. As always, there will be great workshops and presentations from our members and task forces.

For NCAA basketball fans, March is known as “March Madness” and Indianapolis is known as the amateur sports capital of the world. From our hotel, we have easy walking access to the NCAA Headquarters in the White River State Park and many other attractions and downtown restaurants. This would be a great meeting to bring a family.

Plan on joining us for a fun and unique meeting that will celebrate COMSEP’s 20 years. We will include video highlights of Chris White’s COMSEP record breaking drive in an Indy race car at the Indianapolis Motor Speedway, home of the Indy 500 (his move to go low out of turn 4 to lap a car was something to see!). We will end our meeting with a special COMSEP birthday party at the Indianapolis Children’s Museum, the world’s largest (and best) children’s museum. Indianapolis will be sure to have something for everyone from our new members to past presidents and we can’t wait for March!

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Annual Survey Reminder

Submitted by:

Sherilyn Smith and the COMSEP Survey Committee ssmit1@u.washington.edu

I am writing to put in another plug to complete the COMSEP annual survey soon. The survey is relatively new and is an opportunity for COMSEP members to help guide the direction of the organization and is an important vehicle for scholarship for our members.

There are two main sources of questions that are included in the survey. Taskforces submit questions to the survey to help determine priorities for future work. For example, the information from these questions will help the curriculum task force modify the COMSEP curriculum and create useful tools for your clerkship. Answers to questions about the journal club will help guide the form and frequency of this valuable review. In addition to taskforce related questions, individual COMSEP members can submit research questions. We provide preliminary results to researchers by December 1st so they can submit abstracts for presentation at the upcoming COMSEP meeting. Last year, Terry Kind's presented your views about the use of social media, and Melissa Held presented your views about barriers to assessing and remediating issues of professionalism. Linda Lewin's questions about oral presentations are being combined with an internal medicine colleagues results for publication.

So, fill out the survey and be creative! Help guide COMSEP, find out others views on important topics and submit your own research questions. I am happy to answer questions about this process.

Annual Survey Deadline: December 31, 2011

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Announcing: COMSEP Awards Program

Submitted by:
Lisa Leggio lleggio@georgiahealth.edu
Angela Mihalic angela.mihalic@utsouthwestern.edu
Chris White cwhite@georgiahealth.edu

Dear COMSEP colleagues:

In November 2010, COMSEP created our 5 year strategic plan. One of our goals was to enhance the professional development of our members. As an action step, we sought to develop new ways to highlight the amazing accomplishments of those in COMSEP. The Executive Committee expressed wide support for the creation of a COMSEP awards program and we are now pleased to unveil it.

The COMSEP awards program will have three goals:

1. To ensure COMSEP members are aware of national awards that they may be eligible for.
2. To make COMSEP members aware of prestigious institutional or national awards which have recently been awarded to COMSEP members.
3. To accept nominations and distribute COMSEP awards to current and past COMSEP members at the COMSEP annual meeting.

We are now accepting nominations for COMSEP awards in the four following categories:

- Teaching / Education
- Research / Scholarship
- Excellence in Clerkship Administration.
- The COMSEP Achievement Award

If you are interested in nominating a current or former COMSEP member for one or more of these awards, please visit http://www.comsep.org/awards12/.

Sincerely,
The COMSEP Nominating and Awards Committee

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COMSEP Journal Club

Submitted by:
Susan Bannister susan.bannister@albertahealthservices.ca
Editor, Journal Club, *The Pediatric Educator*

Hello!

Welcome to COMSEP's Journal Club – published here in *The Pediatric Educator!* The purpose of this is two-fold: 1) to provide COMSEP members with a scholarly opportunity to review articles, and 2) to provide COMSEP members with reviews of some neat educational articles.

I am delighted to present seven reviews here from eight different reviewers! Thank you to everyone for contributing – for finding articles that we probably wouldn't have otherwise read, for writing reviews that summarize the articles, for making us consider what we do daily in education and encouraging us to reflect upon it, for enabling this edition of the Journal Club to be the largest in recent memory!

The Journal Club will be meeting at the COMSEP meeting – at the Networking Lunch. COMSEP members who have written reviews, who would like to write reviews, who have ideas on how to improve the Journal Club, or who just want to hang out with us are welcome! See you there!

I welcome more reviewers – it would be fantastic to have more members of COMSEP involved. If you are interested in reviewing an article, this is the basic format:

1. Find a neat article that you are interested in (probably others will be interested too!)
2. Read the article
3. Write a review (500 words maximum) with the following headings:
    - What was the study question?
    - How was the study done?
    - What were the results?
    - What are the implications of these findings?
4. Send the review to me
5. Await to see your name in print!

Please let me know if you'd like to review an article or if you have feedback on this format. Thanks!

Curiosity and medical education

Dyche L, Epstein RM. *Medical Education* 2011; **45**:663-668.

Reviewed by Susan Bannister

What was the study question?

What are the barriers to, and the facilitators of, curiosity in the education of doctors?

How was the study done?
The authors qualitatively reviewed the literature and conducted a "theory-driven conceptual exploration".

What were the results?
The authors argue that curiosity is essential for clinical reasoning and excellent patient care as it promotes a strong doctor-patient relationship and results in more accurate diagnoses. Dyche and Epstein describe educational practices that suppress curiosity and those that support it. Factors that can suppress curiosity include: celebrating efficiency (resulting in compromised data collection and decision making), suppressing

negative emotions (which interfers with rational thinking), promoting passive learning (in which the learner chooses the "safe" route of silence rather than expressing curiosity), and rewarding overconfidence (which has been lined to diagnostic errors).

In contrast, factors that can support curiosity include: allowing time for reflection (to consolidate and contextualize knowledge), encouraging questions (which will enhance diagnostic reasoning), modeling uncertainty, and considering multiple perspectives.

What are the implications of these findings?
Curiosity has received little attention in the medical literature. This paper – along with two commentaries in the same issue (details listed below) – challenges medical educators to reflect upon our own teaching practices and become facilitators of curiosity among our students.

Two commentaries are:
Roman R. Curiosity: A best practice in medical education. *Medical Education* 2011; **45**:654-656. Said Roman "Without curiosity, the wonder and awe of taking care of patients is obliterated and the critical thinking that is necessary for effective patient care is lost."

Werner A, Rieber N, Zipfel S. Curiosity's curious influence on medical doctors. *Medical Education* 2011; **45**:656-658. "Maintaining curiosity means tolerating ambiguity, expecting the unexpected, and openly welcoming new thougths even if they do not fit into what was previously known."

Faculty Career Tracks at U.S. Medical Schools
Coleman MM, Richard GV. Acad Med 2011;86(8):932-937

Reviewed by William V. Raszka

What is the problem and what is known about it so far?
Today, fewer and fewer faculty can be productive teachers, researchers, and clinicians. Faculty generally concentrate in one or at the most two of these areas at the expense of the others. Whether traditional promotion tracks at medical schools have kept up with changes in practice is not known. While recent research in the last 15 years suggests that more career tracks are being offered the characteristics of schools that offer more tracks or tenure with those tracks is not known.

Why did the researchers do this particular study?
The authors sought to define the numbers and types of career tracks available in medical schools and learn the institutional characteristics that affect the career tracks offered. While individual schools can use the information to assist in recruitment, the data should provide physicians early in their career a better understanding of academic tracks.

Who was studied?
The study population consisted of the 129 accredited, MD-granting medical schools in the United States that were members of the AAMC as of July 1, 2008

How was the study done?
Between July 2008 and April 2009 researchers conducted Internet searches for faculty policy documents from each institution. Each school's Web site was reviewed for information about available career tracks. The documents reviewed included university catalogs, medical school handbooks, faculty handbooks, and faculty development Web sites. Faculty affairs representatives from all schools were contacted by e-mail. The schools with career policies available online were asked to confirm that that information was still current. Schools without online documents were asked to provide links or attachments containing their current career documents.

What did the researchers find?
Complete data were collected from 98 schools (76%). Schools varied widely in their approach to delineating faculty career tracks. Approximately ½ half offered between three and four career tracks (mean number of

tracks 3.6; range 1-8). Schools offered more research tracks than education or clinical tracks. Of the 79 schools with clearly defined career tracks, 78 offered at least one clinical track and 34 offered at least one education track. There was a stark difference in the specificity and clarity of documentation from one institution to the next. In education tracks, approximately 50% to 85% of a faculty member's effort was expected to be devoted to educational activities. Some descriptions indicated that educational scholarship or educational administration was expected. Of the 39 education tracks, 16 (41%) were tenure-eligible. Only 25% of the clinical tracks were tenured. Almost 2/3 of schools used modified titles for faculty pursuing non-tenure tracks. Schools that offered more career tracks were more likely to use modified titles for their non-tenured clinical and research faculty. Community-based schools offered fewer clinical tracks. Research-intensive schools offered significantly more tenured clinical tracks. No single institutional characteristic was significantly predictive of the way a school structured its faculty tracks.

What were the limitations of the study?
Career tracks assessed were based on information collected from available faculty policies. Some policies may be outdated. Actual institutional practices could vary from published policies, and individual departmental policies might vary from published institutional policies. While data was collected on 76% of schools, given the enormous variability in the school approaches, the remaining 25% could be quite different. Finally, several schools have been accredited since this study and they may have a radically different approach.

Comment: While not an article about teaching methodologies, I found this article fascinating and ultimately somewhat heartening. Maybe it is just me, but I find it grating to be a Professor of Pediatrics (non-tenure) on all my official university documents. That parenthesis, and the institutional policy behind it, seems really outdated. That more universities offer career tracks more closely aligned to what faculty do and that one can become tenured on an education track (however difficult that may be) is a great advance.

Opening the black box of clinical skills assessment via observation: A conceptual model.

Kogan JR, Conforti L, Bernabeo E, Iobst W, Holmboe E. Medical Education 2011;45:1048-1060.

Reviewed by Christopher B. White

What was the study question?
As most clerkship directors know, clinical preceptors vary widely in how they perceive and evaluate the clinical performance of the learners they supervise. The goal of this study was to explore the factors responsible for the variability in resident clinical evaluations made by supervising faculty.

How was the study done?
The study design was excellent – for details, see Figure 1 on page 1050.Forty eight faculty experienced in teaching general internal medicine residents in the ambulatory setting participated. Each watched 4 videos and 2 live encounters of standardized PGY2 residents taking a history, performing a physical exam or counseling a standardized patient. Each case was carefully scripted to show unsatisfactory, satisfactory, or superior resident characteristics in both content and performance. After each of the 6 encounters, faculty completed a mini clinical evaluation exercise (mini-CEX), rating residents on a scale of 1-9, and underwent a structured 15 minute interview by a trained study investigator. For the 2 live encounters, the faculty were given 10 minutes to provide feedback to the standardized resident. Comments by faculty were analyzed by quantitative analysis for emergent themes.

What were the results?
There was significant variability in the ratings for the same resident performance – this was reported in a prior study by the same authors. Four themes were identified to account for the variability among these experienced preceptors. 1) Frame of Reference: Using self, using other doctors, using patient outcomes or using a "gestalt" as the standard upon which to judge resident performance. 2) Inference: i.e. making assumptions about a resident's abilities based on subjective judgments of their observed behavior. 3) Variable approaches and strategies for synthesizing judgments into a numerical score. 4) Other factors external to resident performance: Context (complexity of the patient encounter, resident's prior experience, faculty-

resident relationship) and the resident's response to feedback given by the preceptor.

What are the implications of these findings?
The data emerging from this study shed light on a perennial problem for clerkship and residency directors: why there is so much variability in the subjective grades assigned given by experienced faculty? The authors present a nice conceptual model likening the many factors responsible for grade variation as the lens through which each preceptor sees the learner-patient interaction (p 1056). Having identified what the problem areas are, the next step will be to figure out how to address each of them. Undoubtedly this will require a multi-factorial approach. But the biggest challenge will be to convince all of us who work as clinical preceptors that our own experiences and preconceptions are a major reason for the variability of learner evaluations, and to help us become more mindful and objective as we teach our students and residents.

Editor's note: This well-designed and well-interpreted study causes us to pause the next time we assess a trainee.

Medical Student Outcomes after Family-Centered Bedside Rounds

Cox ED, Schumacher JB, Young HN, Evans MD, Moreno MA, Sigrest TD. AcadPediatr. 2011; 11(5): 403-408.

Reviewed by Tricia McBurney and Sherron Jackson

What was the study question?
What are student' concerns, teaching evaluations, and attitudes after experiencing Family-Centered Bedside Rounds (FCBR) on the pediatric clerkship?

How was the study done?
The setting was a free-standing children's hospital with 88 beds in mid-western USA. During a 3-week inpatient experience (8-week clerkship), 4 students rounded at the beside with 1 attending (7 hospitalists), a senior resident, two interns, the patient's nurse, and any other team members who chose to join rounds. Pre-clerkship and post-clerkship surveys were obtained for 113 of the 127 (89%) medical students for the 2008-2010 academic years. Attitudes about FCBR were assessed on both the pre-survey and post-survey. The post-survey assessed student concerns about FCBR and also student evaluations of teaching during FCBR. Student attitudes were measured by 4 items on a 7 point scale. Student concerns were measured by 14 items and teaching experiences were measured by 11 items; both concerns and teaching experiences were on a 5-point scale.

What were the results?
Post-clerkship, the students were significantly more positive about the benefits of FCBR for patients/families (mean change .37 points, $p < .001$). Interestingly, the students were neutral about preferring FCBR over "sit down" rounds (no significant change after the clerkship). The top 2 concerns of students were presenting information in a way that was understandable to the patients and families on rounds (34.5% of students reported as a frequent concern) and presenting in front of patients and families (25.1%). Only 20.3% of the students reported that effective teaching of physical exam skills was frequent on FCBR. Less than 40% of the students reported as frequent the following: allowing students the opportunity to answer patient and family questions and helping students develop relationship-building skills with families.

What are the implications of these findings?
The American Academy of Pediatrics, the Residency Review Committee for Pediatrics, and the Joint Commission all endorse FCBR. It is critical to consider how we can maximize learning for the medical students on FCBR. The students apparently recognize that the FCBR are better for patients and families, so why do the students not prefer these rounds over "sit down" rounds? This article points out many teaching opportunities on FCBR that can be done well. Maybe, all patient encounters at the bedside do not lead to certain teaching items or opportunities. For instance, which bedside encounters are most appropriate for PE?

Editor's note: This study is important because it reminds us that even though most stakeholders think Family-Centred Bedside Rounds are fantastic, we may not be optimally serving the medical students with this model. We need to carefully determine how we can best optimize learning for all trainees with this model.

Empathy Decline and Its Reasons: A Systematic Review of Studies With Medical Students and Residents;

Neumann, M; Edelhäuser, F; et al. Academic Medicine 86(8), August 2011, 996-1009.

Reviewed by Julie Byerley

What was the study question?

How does empathy change during medical education and what factors influence this change?

How was the study done?

This is a systematic review of the literature on empathy decline in medical students and residents. Quantitative and qualitative studies on the topic published 1990- January, 2010 were identified in several databases. Eighteen non-intervention studies were identified, 11 on medical students and 7 on residents. Fifteen of the studies were performed in the United States, one in Poland and two in the United Kingdom. All studies used self-assessment surveys of empathy. Some were longitudinal and others cross sectional in design. Typical systematic review techniques were employed.

What were the results?

All except one study suggested a decline in empathy over time during clinical training with the most significant change in empathy occurring in the clinical years. Not all potential factors of influence were considered. The influence of gender and age on loss of empathy was not consistent over the studies. When medical field was included as part of the study, medical students choosing patient-oriented specialties had higher empathy scores than students choosing more patient-remote fields (radiology and surgery were the examples used as patient-remote). Distress including burnout, low sense of well-being, and depression was identified as a main cause of empathy decline. Attempts were made to identify the causes of medical student distress. Maltreatment of learners by their educators, challenges in continuing relationships with social supports, and high student work load were cited as factors of influence on student distress. In addition, student idealism was perceived as vulnerable when harsh clinical realities were faced, leading to empathy decline. Concurrent with this is the student shift in focus from a pre-medical humanistic style to an educated, more objective one. Additional contributors to empathy loss include lack of continuity with patients, lack of role models in the clinical setting, and challenges faced in the learning environment. These problems are enhanced by feelings of uncertainty, concern for academic failure, and isolation of learners.

The discussion section of the paper also describes some fascinating neurophysiologic studies documenting down-regulation of sensory processing regarding empathy in physician brains and changes in mirror neurons that occur in response to distress.

What are the implications of these findings?

Empathy is an important element of communication and professionalism in clinical encounters and has been shown to contribute positively to health outcomes. To sustain medical student empathy and therefore improve the therapeutic physician patient relationship, educators should work to sustain empathy. Given that medical student distress was the factor most significantly identified as decreasing empathy and that empathy of the physician has been directly related to patient outcomes, it can be concluded that supporting medical student wellness is a key factor in improving patient health. Efforts to address the formal, informal, and hidden curriculum to decrease distress and improve the learning environment should be supported by medical student educators.

Editor's note: As Dr. Byerley points out, optimizing student learning requires not only relevant objectives, awesome teaching sessions, and regular feedback. It requires that we assist in decreasing students' distress so that they are able to learn.

Medical Students' Self-Reported Empathy and Simulated patients' Assessment of Student Empathy: An Analysis by Gender and Ethnicity

Berg K, Majdan J, Berg D et al. Academic Medicine 2011;86:984-988

Reviewed by Margaret Golden

What was the study question?
What is the contribution of students' ethnicity and gender to the assessments of student empathy by standardized patients (SP)? How do SP scores compare to students' own assessments of their empathy?

How was the study done?
For one class of 248 students, during the school's summative OSCE with standardized patients, students' self-assessment scores of empathy were compared to the SP's scores of how well students were able to convey both empathy and support.

What were the results?
Standardized patients rated female students higher than male students in terms of empathy. They also rated white students higher than Asian American students (effect size 0.56 and 0.43, for the itemized and global scales respectively.) Meanwhile, the self-ratings for empathy were the same for students self-identified as white and those self-identified as Asian.

What are the implications of these findings?
The authors wonder if and worry that these findings point to an important bias against Asian students on high stakes exams both locally and nationally. Their discussion addresses the need to fine tune the measurement tools and SP training to reduce this bias. An alternative approach is to accept that the SPs are assessing their own experiences of the encounters accurately: not all students in their 4th year of medical school are equally able to connect with patients. If this is the case, medical schools need to carefully diagnose each student's communication skills early in the curriculum, and provide ongoing, individualized interventions. Admittedly, this is a huge task; but, can we do less?

Editor's note: A second article about empathy but with a completely different focus! While the literature is quite clear that self-assessment cannot be done well, this study is important because it raises an important question: Are standardized patients biased by ethnicity and gender when dealing with medical students. As the authors conclude, this needs further study.

Remediation of the Deficiencies of Physicians Across the Continuum From Medical School to Practice: A Thematic Review of the Literature

Karen E. Hauer, MD, Andrea Ciccone, MS, Thomas R. Henzel, EdD, Peter Katsufrakis, MD, MBA, Stephen H. Miller, MD, MPH, William A. Norcross, MD, Maxine A. Papadakis, MD, and David M. Irby, PhD. Acad Med. 2009; 84:1822–1832.

Reviewed by Lavjay Butani

What was the study question?
The purpose of the study was to determine if the medical education literature could provide an ideal model of remediation as assessed by two measures: clearly stated outcome measures, and targeting varying levels of learners (undergraduate, graduate and practicing professionals).

How was the study done?
A MEDLINE literature search through October 2008 was performed by one of the investigators using terms related to remediation and other areas such as clinical competence. Bibliographies of retrieved articles were manually searched for additional studies. Opinion articles and reviews were excluded. Based on consensus and small group review, only those studies that addressed the following 3 components of remediation were included: description of how the deficiency was assessed, the educational intervention, and strategy for reassessment of deficiency. A standardized data extraction form based on the Best Evidence Medical Education Collaboration project was used. The robustness and impact of the reassessment strategy used was classified based on Kirkpatrick's 4 levels of assessment.

What were the results?
Of the 170 articles selected for review, only 13 met eligibility criteria for inclusion; 7 addressed remediation of medical student performance, 2 focused on resident performance issues and 4 studies assessed practicing physicians' performance deficiencies. Interestingly, in none of the student and resident focused papers were learner deficits identified during actual clinical performance; rather the articles dealt with remediation of deficiencies on knowledge based tests/in-service examinations or clinical deficits based on standardized patient (SP) encounters. The intervention strategies included tutorials, directed readings, one on one discussions with a mentor, and precepted video reviews of SP encounters. Re-testing strategies for the most part involved use of the same assessment that led to the initial identification of problem performance; all studies showed an improvement in learner knowledge and skills (Kirkpatrick level 2). None of these studies assessed learner behaviors or patient outcomes. The 4 studies addressing practitioner performance (all from Canada) identified deficits using peer assessors and licensing organizations. Remediation included tutorials, clinical training, readings, and coaching. Retesting strategies were of a higher level in 3 studies (Kirkpatrick Level 3), assessing change in physician's behavior, while in the 4th, the only outcome assessed was practitioner satisfaction (Kirkpatrick Level 1). All studies demonstrated improvements after the intervention.

What are the implications of these findings?
This review highlights the gap in the medical education literature pertaining to a critical area - how to design, implement and assess the success of intervention strategies once learners with difficulty have been identified. With greater emphasis on competency-based instruction and assessment, it will become even more critical for educators to engage in scholarship addressing how to be successful in remediating learners. This would then be followed by the designing of a tailored educational intervention strategy and finally to the development of valid and meaningful assessment tools addressing higher levels of outcomes (behavior change). This, obviously, involves lots of resources and time, neither of which is easy to come by. Multi-institutional collaboration is one way to pool resources and expertise to answer these questions. We know that evaluation drives performance, but if we don't know how best to teach learners who are having difficulty, how can we close the loop and expect our learners to succeed? It's time to advance this area, an area that is ripe for scholarly activity!

Editor's note: As the authors conclude, there is little evidence-based guidance on how to best remediate trainees in medical education – perhaps COMSEP will take this on and contribute to this field of study.

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