First of all, a special thanks to Dr. Stan Shulman and the Editorial Advisory board of Pediatric Annals for including an issue around the obvious and not-so obvious connections between medical education and the general pediatrician in an ever-changing and dynamic world. This topic is rarely visited in the depth and breadth seen in the articles in this edition. Because I am a generalist with a special life-long interest in medical education, I have a special affinity for both.

One of the most life-changing experiences in my early academic career in the mid-1970s was my serendipitous visit to the then Center for Educational Development at the University of Illinois. It was here that I met an individual who was to become my mentor, Dr. Richard Foley, and the father of medical education, Dr. George Miller. When I met with Dr. Miller, he asked me what I was doing and was very attentive to my early initiatives. When I finished relating my activities and interests, he asked, “What you are doing seems wonderful, but how are you affecting people around you?” He then got up from his chair, went to one of his many bookshelves encircling his office, and chose a few books for me to see. All of them had the common theme of change. I will never forget that critical incident in my career and, to this day, I have always remembered that question as I have pursued excellence in medical education. Change is one of the underlying themes in this edition of Pediatric Annals.

Since the publication of the Flexner report in 1910, there have been many calls for change and reform in the way we educate our future physicians and ultimately our patients. One of the most significant changes has been the shift in emphasis from the inpatient to the ambulatory setting to educate our trainees. Whereas most teaching in clerkships and residencies occurred in the hospital until the late 20th century, this focus has moved to offices in the community and academic health center because that is where most patients receive their care. In pediatrics in the past 3 decades, we have seen the concomitant birth of the concept of continuity of care imbedded in residents’ patient care experiences. Many of these experiences take place in community pediatricians’ offices, complementing the curriculum in the academic health center. These opportunities provide the trainee with a first-hand look at the intricacies of pediatric practice, not only in regard to how pediatricians approach problems in the community as compared with the academic setting (eg, the febrile 3-month-old) but also how a practice actually functions administratively.

Nagappan et al address the role of the pediatrician in training residents and medical students in a community office setting. DeWitt and Roberts published the first articles on teaching in the office with an emphasis on faculty development for community preceptors. In the article in this issue, they categorize the key issues around needs of the learner as the
As a complementary article to the advantages of teaching in the office, Allevi and Lane define and outline some micro-teaching skills that should assist pediatricians in balancing their patient care and teaching responsibilities in the office setting. Whereas all the skills mentioned are not evidence-based, they have all been used effectively by clinician-educators to maximize learning in the ambulatory setting. They also address the important issue of teaching in the presence of the patient and when this is indicated/contraindicated. This technique allows the pediatrician to observe first-hand the interactions between the trainee and patient/parent.

We have seen an information and technology explosion that has not only improved how physicians practice, but has also enabled patients and families to be more self-empowered about their wellness and illnesses. Parents are bombarded with truths, half-truths, and inaccuracies about child health and disease. The most publicized example of this has been the alleged association between childhood vaccines and autism, leading to parents refusing vaccines for their children, despite research refuting this link. D’Alessandro addresses the difficult task of how to provide parent and patient education in this world of easily accessible information. Recent studies have addressed the issue that the amount of anticipatory guidance appropriate for each well baby/child/adolescent visit is far beyond the time limits any pediatrician can afford. This makes patient education a challenge. D’Alessandro focuses on a number of important issues in this article: 1) categorizing the options for patient education in the office, 2) empowering parents and patients to be more proactive players in the interaction, and 3) assessing the quality of information.

A topic not previously addressed in any detail in the literature is the relationship between hospitalists and the referring general pediatrician. The hospitalist movement is in its infancy, having occurred in the past 15 years and even more recently in pediatrics. Initial studies involving hospitalists have focused on the efficacy and efficiency of care, specifically around length of stay and costs. Subsequent studies have addressed quality of care and outcomes. The missing link is defining the relationship between the referring pediatrician and the hospitalist in regards to the competency the Accreditation Council for Graduate Medical Education (ACGME) calls systems-based practice. Seelbach and Ottolini explore communication opportunities, starting with the admission of a patient through discharge. Obviously, making this process seamless is the ultimate goal so that there are no gaps or misunderstandings around patient care.

Shipman’s article highlights two themes among many throughout his article, namely, one that touches on manpower or (more appropriately today in pediatrics) womanpower, and how changes in practice have affected the curriculum for training future pediatricians. He reviews the major changes in practice that have occurred in the past few decades, including the shifts from infectious diseases dominating patient care to the new morbidity described by Haggerty. He outlines the movement of inpatient pediatrics to ambulatory settings and how subspecialization has affected the general pediatrician’s role in patient care. He also briefly describes the advent of the hospitalist and how that movement has changed how generalists practice. All of these shifts and innovations have shaken the foundation of traditional general pediatrics as we have known it the past 50 years and have stimulated a movement to relook at the way we educate future practitioners.

The community-oriented primary care (COPC) movement is reviewed by four former fellows in the general academic pediatrics training program at Children’s National Medical Center in Washington (Chen, et al, all of whom I had the pleasure of teaching) and identifies how primary care and public health issues converge. The con-
cepts of COPC involve continuous care provided to a community on the basis of the needs of that community using public health principles in an organized way. General pediatricians, among other healthcare professionals, are often major players in this endeavor. In this important world-wide model, citizens from within a given community not only input into what the community sees as priorities in healthcare but also have many of their own involved in helping to deliver that care. This model is the basis for some general academic pediatric fellowship programs and trainees often enter underserved communities when they finish their fellowship.

The article by Greenberg and Bickel raises an issue not well-documented in the literature: Do clinician-educators, many of whom are generalists, get promoted and attain job satisfaction comparable to their subspecialty peers? Are they able to produce scholarship in a very revenue-driven ambulatory environment? The authors define the term “clinician-educator,” discuss the scholarship of teaching (versus teaching excellence) as a way to attain job satisfaction and promotion, and suggest that leaders in pediatrics survey generalists to answer the questions we have posed.

In summary, I hope we have demonstrated a potentially strong connection between the general pediatrician and issues within medical education. I hope that these articles challenge, inspire, and stimulate generalists in the areas addressed to take action and make a difference in educating future physicians and patients and families.

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