Commentary: Educational Planning to Achieve the Goals of Community Pediatrics

Kenneth B. Roberts, MD

ABBREVIATION. AAP, American Academy of Pediatrics.

In “Teaching Community Pediatrics to Pediatric Residents: Strategic Approaches and Successful Models for Education in Community Health and Child Advocacy,” Shipley et al provide useful, practical suggestions and models for building and implementing community-pediatrics experiences during residency. To identify where they fit in the overall goal of improving child health through community pediatrics, it is useful to consider the steps in the educational planning process, which can be summarized in the mnemonic GNOME: G stands for goals, N for needs assessment, O for objectives, M for methods, and E for evaluation. Goals are intended to be aspirational and often are vague; needs assessment identifies the gap between the learners’ starting point and achieving the goals; objectives are specific, measurable steps to fill the gap; methods are the educational strategies designed and implemented to meet the objectives; and evaluation identifies whether the goals have been met.

Rarely are goals expressed as articulately as the goals of community pediatrics, defined by the American Academy of Pediatrics (AAP) Committee on Community Health Services. Model objectives for residency training in community pediatrics have been specified by a collaborative working group of Dyson Initiative sites and the team revising the Ambulatory Pediatric Association educational guidelines for pediatric residency. Also, the article by Shipley et al gives examples of methods that can be used to achieve the objectives, a valuable addition to the descriptive literature of such programs. These offerings, then, address the G, O, and M of the mnemonic; what of the N and E?

Residents’ needs and desires are critical to consider when planning such educational programs. As DeWitt points out in his excellent article, “The Application of Social and Adult Learning Theory to Training in Community Pediatrics, Social Justice, and Child Advocacy”: “People cannot be told that they have to be motivated,” and “People do things for their own reasons, not for yours.” Medical school graduates enter residency to develop in their roles as medical doctors. They have been students of medicine and medical school. Now they apprentice to perform medical school as doctors. They have been students of medicine and doing; now they apprentice to perform the work of medicine and become the doctors they aspire to be. Patient care does not need to be “sold” to them as the basis of residency; even here, there is a desire on the part of residents for the clinical experience to be relevant and immediately useful. Given what is known about adult learning, this certainly is not surprising.

How can community pediatrics, as defined in this supplement, avoid being considered extra or not directly applicable? The key factor here is the credibility of the message as delivered and integrated locally. There need to be available credible role models (not just espousers); the residency program needs to create expectations, commit resources to achieve the expectations (such as protected time), and follow through on monitoring and highlighting achievement; and the department needs to support the aspiration of community pediatrics in action and spirit as well as in rhetoric. These conditions are met in the programs described by Shipley et al, and the applicants to those programs recognize the opportunity to have their own aspirations for community pediatrics flourish in such an environment. (We need to remember this potential selection bias when we consider evaluation.)

Short-term evaluation (using self-report, number of projects completed, and projects continued beyond the protected time) demonstrates that residents can achieve the proposed objectives and competencies when the principles and models described by Shipley et al and others are applied. However, will the programs achieve the desired goal of increasing the practice of community pediatrics among graduates in the years after residency, or will market forces curb the enthusiasm for community pediatrics and foster the atrophy of community-pediatrics skills along with other hard-won abilities infrequently used in practice such as intubation and umbilical catheter insertion? In 1999, when the AAP Committee on Community Health Services published its statement on community pediatrics, Haggerty posed 2 questions concerning community pediatrics: “Can it be taught?” and “Can it be practiced?” The answer to the former seems to be affirmative. The answer to the latter, citing specific examples, is that it can, but whether it will be practiced more widely as...
a result of residency-based initiatives, changing the face of pediatric practice, remains unknown. It is hoped that the residency programs described here will generate graduates who will find or create supportive environments in which to continue to practice community pediatrics, thus becoming the next generation of role models to inspire new residents. Efforts to recruit current practitioners are critical, of course, requiring the continued active involvement of the AAP.

We await the evaluation results of the Dyson Initiative to learn whether graduates will continue to practice community pediatrics, and then we can return to the GNOME paradigm and the recognition that the steps in the educational planning process are not linear but circular2 (see Fig 1). If the evaluation results fall short of what is desired, a new needs assessment is required and new objectives and strategies (methods) must be applied. If the evaluation results demonstrate the desired outcome, then we have a new goal: generalizing the practice of community pediatrics to more offices and generalizing the benefit to more children and communities.

REFERENCES
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