Pediatric training programs are now faced with the daunting challenge of shifting toward competency-based education in teaching their residents. This shift in educational focus comes on the heels of earlier recommendations in the mid-1990s to encourage increased learning in an outpatient setting rather than solely in an inpatient, hospital-based environment. Given all these changes in the structure of graduate medical education, it should come as no surprise that residency directors (and their associates) have begun scrambling to identify ways to easily address all of these issues in an effective and time-sensitive manner. In the articles by Garfunkel et al and Rezet et al, the authors address this challenge head-on and offer what may soon become the blueprint for how community-pediatrics programs can build their own educational curricula geared toward competency-based residency education.

Although the transition toward competency in medical education is critically important in guaranteeing the graduation of high-caliber pediatricians, the need for a continued focus in community pediatrics during residency training is also clear. In an article by Shope et al, the authors list multiple citations in which residency graduates in pediatrics “consistently identified the need to have more education in school health, child advocacy, behavioral pediatrics, and accessing community resources.” Moreover, Cull et al showed that despite the 1996 recommendations from the Residency Review Committee to increase training in child advocacy, only half of graduating residents in 2002 rated their educational experiences in this area as “very good” or better. It is for these reasons that the domains established in these articles come at such an opportune time. By defining the 8 core areas of community pediatrics, residency programs can better address the educational needs of their residents, perhaps even using the domains as the backbone for curricular development in this arena. In addition, subtle differences in training goals (eg, rural versus urban settings) can be identified and addressed. It is most important that by cross-referencing these domains and their objectives (see Rezet et al) to the 6 major competency domains established by the Accreditation Council for Graduate Medical Education, community pediatrics has taken a major step toward ensuring its continued place in the broader scope of clinical training.

Having recently completed residency, I can greatly appreciate the need for comprehensive, competency-based training in all areas of medicine, including community pediatrics. We should be troubled that although pediatric residents are well trained in the endocrinology of obesity, they often fail to realize the ineffectiveness of recommending “less-fattening meals” and “more aerobic exercise” to those families with obese children who may have little money, when healthy foods cost more than their fast-food alternatives, and their neighborhoods lack safe environments for walking and outdoor play. In the end, as we strive to produce the best-trained pediatricians possible, we must embrace any and all efforts made toward ensuring competence in graduate medical education. Achieving consensus on competency training in community pediatrics is certainly a step in the right direction.

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