Teaching the Essentials of “Well-Child Care”: Inspiring Proficiency and Passion

Before the pediatric clerkship, most medical students learn to take a patient history starting with the “chief complaint.” Upon encountering their first pediatric patients, students quickly recognize that they are not prepared to ask the appropriate follow-up questions when the chief complaint is “well-child visit.” In this article, we present a practical method for teaching medical students how to approach pediatric health supervision visits that build upon their existing clinical skills.

Primary care pediatricians address the health care needs of each child in the context of their family and community. They acknowledge the important ways in which social and psychological determinants of health impact wellness. Clinical teachers of pediatrics can inspire future physicians to use patient-centered communication skills to address the needs and priorities of families by making explicit the different aspects of a pediatric health supervision visit that include the following:

1. Identifying patient and family concerns by practicing a structured communication strategy.
2. Using reliable resources to identify the established priorities for each age and access most up-to-date anticipatory guidance recommendations.
3. Delivering prioritized anticipatory guidance that is specific to each patient within his or her community.

**COMMUNICATION STRATEGY**

A useful strategy for approaching the conversation with parents and children is for students to: “Elicit and ask...then assess, prioritize, and advise.” Clinical preceptors should explain the importance of eliciting patient and family concerns by asking open-ended questions. Then, with feedback on their ability to assess the most important issues, preceptors ask students to prioritize which topics to address and then together, advise the family accordingly.

Eliciting concerns through open-ended questions creates the essential foundation for the health supervision visit. Recent studies have demonstrated that using a patient-centered communication style with open-ended questions is not only time-effective but allows for greater adherence to the current standards for well-child care practice. If “closed-ended” or “leading questions” are used, the student risks neglecting the family’s concerns and may deliver advice that does not meet the needs of their patients. In fact, students often need to elicit concerns several times during the encounter because the more sensitive concerns such as financial insecurity or family discord are frequently uncovered after the student builds rapport. We direct students to use the acronym CHEC (k)-UP when taking a complete history for a well-child visit that prioritizes obtaining the patient concerns first and again at the end of the visit:
Although the components of a “complete history” are familiar to students, the specific components of a health supervision history may be new to them. In particular, pediatricians can explain the tenets of collecting a developmental history that includes surveillance as well as formal screening.6 Table 1 contains a list of possible open-ended questions that we developed for students to use. The first question listed in the table can be used to open the visit so that family and patient concerns are collected up front. Students can also be taught to ask questions that highlight family and patient strengths in addition to uncovering risk factors. For example, “What new things is your child doing?” instead of “Is your child using at least fifty words?”7

After completing the history and a physical examination, students should organize their data and synthesize an assessment of the visit by presenting a concise oral presentation.8 After discussing these interpretations with their preceptor, students should make an attempt to prioritize the topics for anticipatory guidance and either observe their preceptor or directly advise or counsel the patient and family themselves.

RELIABLE RESOURCES

In 2008, the American Academy of Pediatrics published a new set of health supervision guidelines, Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, third edition.9 This edition includes the text, a pocket guide along with a tool, and resource kit for implementation. Students can access the pocket guide version of this text electronically.9 The overarching themes are listed below:

**TABLE 1** Open-ended Questions for Well-Child Visits: Key Topics and *Bright Futures* Themes

<table>
<thead>
<tr>
<th>Key Topics for Anticipatory Guidance</th>
<th>Bright Futures Themes</th>
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<tbody>
<tr>
<td>Patient and family concerns</td>
<td>Family-centered communication</td>
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<tr>
<td>Home</td>
<td>Family support</td>
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<tr>
<td>Day/nights/routines</td>
<td>Physical activity</td>
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<tr>
<td>Diet/nutrition</td>
<td>Mental health</td>
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<td>Development/behavior</td>
<td>Child development</td>
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<td>Oral health</td>
<td>Healthy sexual development</td>
</tr>
<tr>
<td>Safety</td>
<td>Safety and injury prevention</td>
</tr>
</tbody>
</table>

*The Bright Futures Pocket Guide provides a “menu” of 5 possible anticipatory guidance topics for each age from newborn to age 21, such as an introduction to oral health at 6 months of age and developmental and mental health assessment for children 8 years of age.* Students can self-identify knowledge gaps related to these common anticipatory guidance topics. For example, a student may choose to learn more about effective discipline, early literacy, or car seat safety by accessing trustworthy parental resources online such as www.caringforkids.cps.ca, www.cdc.gov/parents, or www.healthychildren.org.

**ANTICIPATORY GUIDANCE**

Before the first encounter, clinical teachers should clearly convey their expectations so that students know whether to address concerns independently or wait until they have reviewed their approach with the preceptor. Pediatricians should explain to students how they identify
the most important advice for each individual patient and family based on their personal knowledge of the child and understanding of the community context in which that child lives. For example, clinical teachers can explain how they choose to target injury prevention based on the rural, suburban, or urban context of the patients in their communities: Pool safety might be prioritized for a child learning to swim in the summer, whereas the occupational hazards related to heavy machinery and animals would be reserved for children who live on a farm.

Students should avoid using the *Bright Futures Pocket Guide* as a “checklist” of items to complete because patients and families are likely to only recall a fraction of what is discussed. In fact, *Bright Futures* is not meant to be a checklist but a guide or menu of options that allow the provider to select items within each domain to match the needs of the patient, provider, and communities (G. Blaschke, MD, MPH, personal communication, 2014). Providers demonstrate the principles of prioritization by identifying and addressing individual patient concerns while balancing what is known about health promotion, injury prevention, and the strengths and needs of the community. In addition, when providers acknowledge and support the family who knows that child best, long-term relationship building can be modeled effectively.

Most students at this stage in their training are likely to require guidance on how to effectively influence behavior change using patient-centered interview techniques. Behavior change, such as tobacco cessation or alcohol and drug screening in adolescents, can be facilitated with motivational interviewing and brief interventions.

Preceptors can help teach the basics of these skills by asking students to practice sharing information about one of the prioritized topics by role-playing a parent or older child while the student attempts to offer them advice. Advanced students may also be able to identify barriers to implementation and assess whether the family has accurately understood the information. Student communication skills can further improve when a clinical teacher “debriefs” with the student after the visit by explicitly describing the process that guided his or her actions during the consultation.

When students are able to access reliable resources for information, they are better equipped to self-identify knowledge gaps and practice delivering prioritized advice with supervision. By using the “Elicit and ask…then assess, prioritize, and advise” patient-centered communication strategy, students learn to balance “their” agenda with the agenda of the patient and family. With a few weeks of supervised practice, students learn to address each patient’s most pressing needs and provide advice that is informed by evidence and specifically targeted to each patient in the context of their family and community. Moreover, students are likely to overcome their initial “fears” of pediatric patients whereby they can come to enjoy the moments that bring families back to their trusted partner who supports the care for their developing child.

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**REFERENCES**


12. Mounsey AL, Bovbjerg V, White L, Gazewood J. Do students develop better motivational interviewing skills through role-play with standardised patients or with student colleagues? *Med Educ.*. 2006;40(8):775–780


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