Collaborative Office Rounds: Continuing Education in the Psychosocial/Developmental Aspects of Child Health

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ABSTRACT. Objectives. In recent years there has been increasing emphasis on the mental health aspects of primary health care for children and adolescents. The Health Resources and Services Administration’s Maternal and Child Health Bureau has contributed to efforts aimed at strengthening primary care not only in early identification and beginning intervention with mental disorders, but also in prevention of emotional and behavioral problems and in promotion of positive psychosocial development. The Collaborative Office Rounds (COR) Program is a noteworthy part of these efforts.

Methods. The COR program supports small discussion groups that meet at regular intervals over sustained periods of time to address the mental health aspects of pediatric care. The groups are jointly led by pediatricians and child psychiatrists. Although they vary in a number of ways, all are concerned with the day-to-day psychosocial issues that confront primary care providers serving children, adolescents, and their families.

Results. COR groups have addressed a wide range of areas including numerous problems and disorders, health supervision issues, family and community topics, personal challenges and practical complexities, and clinical management issues. Evaluation information indicates a positive response on the part of participants and moderators. This is reflected in group stability, high attendance rates, universal readiness to recommend the COR experience, and a variety of collateral accomplishments.

Conclusions. Experience to date points to the COR group as a useful tool for addressing psychosocial issues in primary care. Its potential may be more fully realized by applying this approach more widely, even as further assessment is pursued. Pediatrics 1997;99(4).

DEVELOPMENT OF THE COLLABORATIVE OFFICE ROUNDS (COR) PROGRAM

As part of our ongoing concern with mind and body and our continuing commitment to multidisciplinary approaches in child health care, the Health Resources and Services Administration’s Maternal and Child Health Bureau (MCHB) precursor office convened a meeting of pediatricians and child psychiatrists in the fall of 1988 to consider how to enhance collaboration in education. The focus of the discussions was on the psychosocial-developmental aspects of child health as they impact on children, adolescents, and families.

The 1988 meeting led to a recommendation for the COR discussion group approach. The centerpiece of the approach is a small group experience that promotes the free exchange of ideas and provides for a continuing relationship with the resource faculty and other group members. Constancy in group composition and regularity in meeting frequency are important features that contribute to a sense of collective group identity and to sustained impact. The focus of attention is on clinical situations.

The COR group addresses an increasingly recognized need for there to be a greater focus on mental health issues in physical health care. The groups can contribute to this objective by enhancing skills and sensitivities that the present or future practitioner may have acquired in training. Elements of COR are derived from the work of mental health specialists, but its focus is very much on the unique opportunities and challenges offered by the primary care setting. The COR program provides modest funding as a stimulus to encourage collaborative educational efforts by pediatrics and child psychiatry, and as a vehicle for demonstrating the utility of the COR group experience.

COR PRECURSORS

In 1950, Michael and Enid Balint began to lead groups of British general practitioners in discussion seminars that applied concepts from psychoanalysis to the primary practice of medicine.1 These seminars seem similar to COR in providing an ongoing small group experience that addresses psychosocial issues.

ABBREVIATIONS. COR, Collaborative Office Rounds; MCHB, Maternal and Child Health Bureau.

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However, the nature of their focus on psychodynamics in doctor-patient interactions and on “limited but considerable change of personality” in practitioners extends beyond the scope of COR program objectives. To a degree, related differences appear to have also characterized the discussion seminars when their attention was more limited in focus. Relatively recently, there has been an effort to formulate an approach to Balint-type work that evidently involves a focus on change in caretaking as distinguished from change in caretaker.1

In October 1964, Albert Solnit reported on experiences with pediatric discussion groups in New Haven, CT that originated in 1957.4 He cited initiation of a mixed group of trainees and more senior participants with a child psychiatrist serving as moderator. This evolved into a study group of pediatric practitioners with a child psychiatrist and pediatrician as cochairs. This model closely resembles a number of the current COR groups. Group activity of this kind has continued in New Haven up to the present.

In April 1967, Sumpter and Friedman presented a report on a small group of pediatricians who had started meeting in Rochester, NY in 1964 to discuss cases from their practices that involved emotional/behavioral problems.5 The group had no identified leader, but it did call on outside experts for consultations at times. Although no systematic evaluation of the group experience, referred to as a workshop, was made, the impression was that it, “...meaningfully altered some aspects of the practice of pediatrics for its members.”

THE SPECTRUM OF COR PROJECTS

Initially, COR participants were expected to be primarily practitioners, but COR has since shown promise with fellows and residents as well. Most of the participants in the groups to date have been pediatricians. However, although the membership of these groups has been more homogeneous than envisaged, other aspects of the experience with these projects have been more variable. As a result, these projects present a wide spectrum of COR experiences.

Ten first generation COR projects started in the fall of 1989. In keeping with the program guidance, all 10 projects were jointly sponsored by Pediatrics and Child Psychiatry medical school departments/sections. The grantees were: Case Western Reserve University, Dartmouth College, Duke University, Evanston Hospital (Northwestern University), Rhode Island Hospital (Brown University), The University of Chicago, The University of Connecticut, Vanderbilt University, Washington University—St. Louis, and Yale University. Because, as noted, most of the members were pediatricians, their objectives have been quite similar to objectives originally envisaged for pediatrician participants. These include the following:

1. Enhanced understanding of psychosocial aspects of pediatrics
2. Greater facility in dealing with developmental crises
3. More comprehensive approach to health supervision
4. Fuller appreciation of psychosocial implications of chronic illness and handicap
5. Increased ability to help families
6. Expanded power to discriminate between transient disturbances and more serious psychiatric disorders
7. More highly developed interviewing and counseling skills
8. Heightened awareness of the scope of one’s competency in the area of psychiatric disorders
9. Strengthened orientation to consult with or refer to child psychiatrists or other mental health professionals as appropriate.

All the groups have had at least two child psychiatrists involved as codirector and back-up cooperator and several have had more, with one COR group having an even mix of pediatricians and child psychiatrists. The experience from those groups where child psychiatrists participated in nonleader roles reinforces our belief that the COR group can be a two-way street in which reciprocal gains can be realized by both pediatricians and child psychiatrists.

The educational process in COR has varied considerably. One area of variation relates to the role of case material in the process. All COR groups make extensive use of work with patients, but they approach it in a number of different ways. For instance, one group encourages participants to bring in challenging/interesting cases that are matters of the moment for the presenter. This group assumes that, over the course of a year, a representative sample of case material will be covered, and experience to date seems to support the assumption. Other groups preselect topical foci and invite case reporting that will illustrate the subject under consideration. Sometimes topics are planned to follow developmental sequences; other times particularly prevalent or challenging issues are selected, and the ostensibly unremarkable health supervision visit has also been the object of attention.

In some COR groups, structured didactic elements have been intertwined with the consideration of clinical case material. Although relatively formal teaching remains a feature in certain COR programs, if there has been a trend in the life of COR, it would appear to be in the direction of emphasizing clinical material and learning from the practical challenges and opportunities that are presented when the group considers cases. Nonetheless, other materials are routinely added, usually in the form of supplementary reading, and sometimes through other devices, such as videotaping and simulated interviewing. Visiting experts, community workers, and families are among those who have been invited on occasion to contribute to the discussion in one or more of the groups.

Participation is open-ended for most groups, rather than rotating participants after fixed time segments. This approach promotes a sense of group identity and shared purpose that facilitates mutual
trust and open interchange. MCHB sees limiting the group size to 12 and striving for meetings at least monthly, and preferably biweekly or more often, as ways to reinforce the group process.

One half of the original grantees from the first generation of projects have received support from the second generation COR program; they are Case Western Reserve University, Dartmouth College, Duke University, Vanderbilt University, and Yale University. They have been joined by Children’s Hospital of Cincinnati (University of Cincinnati), Children’s Hospital of Philadelphia (University of Pennsylvania), Indiana University, and The University of Michigan. Also, COR groups have been incorporated as an essential element in 11 behavioral pediatrics projects supported by MCHB.

Behavioral pediatrics COR groups are, on the average, more involved with trainee participants than the freestanding COR projects have been. Many trainees are not able to make the same kind of continuing commitment to the COR process that community practitioners can; nonetheless, they have found purposefully time-limited COR exposure can still be personally meaningful and practically useful.

**PROGRAM CONTENT**

The areas of interest covered by COR groups are wide ranging. Essentially all the expected psychosocial/developmental problems and disorders that the practitioner encounters, as well as some of the more esoteric ones, are represented in the topics collectively addressed by the COR projects. Health supervision, anticipatory guidance, and counseling on developmental challenges and crises are frequently addressed. The focus often extends to the family and community. Personal challenges for the practitioner and practical issues for the practice also draw considerable attention, as do issues in assessment, treatment, consultation, referral, and follow-up. Examples of topics are outlined below:

**Problems and Disorders**
- Conveying “bad news” to parents
- Failure to thrive
- Developmental disorders
- Mental retardation
- Child abuse and neglect
- Sexual abuse
- Attention deficit hyperactivity disorder
- Tourette’s disorder
- Psychosomatic disorders
- Conduct disorders
- Oppositional behavior
- Sociopathy
- Anxiety
- Obsessive compulsive disorder
- Post traumatic stress disorder
- Eating disorders
- Aggression
- Depression
- Bipolar disorder
- Suicidal behavior
- Pervasive developmental disorder
- Autism

**Health Supervision**
- Establishing an alliance with parents prior to birth
- The transition to parenthood
- The neonatal intensive care unit environment and preemie follow-up
- Development in the preterm infant
- Evaluation of the newborn
- Bonding
- Breastfeeding
- Temperament
- Crying and colic
- The vulnerable child
- Infant day care
- Sleeping
- Eating
- Toiletting
- Tantrums
- Toddlerhood
- Discipline
- School readiness
- Social isolation in the school-age child
- Adolescent sexuality
- The sequence of scheduled health supervision visits
- Psychosocial implications of physical pain and procedures
- Chronic physical illness and disability
- Potentially frightening and stigmatizing physical disorders

**Family and Community**
- Family stability
- Family discontinuities
- Parental differences
- Parental separation
- Divorce
- Adoption
- Parents with chronic illness
- Parents with mental illness
- Substance-abusing parents
- Gay parents
- The impact of a child’s death on the family
- Working with schools and community agencies
- Promoting literacy
- Addressing the challenge of gangs and violence

**Personal Challenges/Practical Complexities**
- Patient death
- Ethical issues
- Financing care
- Managed care
- Forensic issues
- Classification issues

**Clinical Management**
- Testing
- Counseling
- Psychotherapy
- Psychotropic medication
- Indications for referral
- Handling ongoing consultation
- Management of complex cases

**EVALUATION**

All COR projects incorporate an evaluation component. These vary considerably in their approach and extent. Among the methods used are observa-
tion of how participants relate to patients and families; detailed chronicling and review of group discussions; and use of questionnaires, often for participants and sometimes for moderators. The questionnaires inquire about a number of issues including psychosocial/developmental orientation, comfort with psychosocial aspects of clinical experience, practice patterns including use of referral and consultation, content and process of individual sessions, and utility of what is derived from the sessions. The findings from across the projects point to positive responses and suggest significant impact.

In addition to individual COR group evaluation efforts, the groups collectively provide information on an annual basis about their experience during the past year, the responses of their participants to the experience, and accomplishments/effects impacting others outside the COR circle. These latter impacts are referred to as spinoffs.

Information from the past 4 years, incorporating input from the first two generations of freestanding COR projects, paints a picture of remarkable stability in the groups. Most groups have reported no change in either of their two comoderators. The departure rate for participants has also reflected a high degree of commitment, with the great majority of participants remaining in COR over the duration of the projects. In addition, participants have expressed universal readiness to recommend the COR experience. Perhaps more revealing than endorsement of COR is the pattern of attendance by participants. The average attendance has remained in a range extending from approximately two-thirds to about three-fourths of the group for each session. Also, participant responses reflect a widely held conviction that COR is well worth the investment of resources; MCHB support has recently averaged $13,000 per project annually.

In evaluating their impact, COR groups document accomplishments beyond those with direct value for their participants. These spinoffs include the following: sponsorship of seminars and courses, influence on change in existing curricula, institution of new faculty positions and new teaching roles, additions to house officer training, development of didactic materials, creation of new clinical programs/services, and establishment of new linkages among medical faculty and between the academic and local service communities.

In addition to specific spinoffs, the COR projects have extended their influence beyond their group members through sharing of information and ideas between participants and their colleagues. This form of dissemination has been preplanned by some projects that recruit participants from group practices so as to expand the area of impact. Evaluative information supplied by the projects documents patterns of sharing.

As suggested by the experience cited, evaluation efforts to date have been encouraging; however, the COR projects have had to confront some challenges during their formative years. Timing of meetings has been one of the areas where adjustments have been necessary. Office hours and parenting responsibili-

ties are two major considerations. Different groups have worked out different arrangements. Among the times set have been early morning hours, evenings, and time slots juxtaposed to events such as grand rounds.

Another issue is presented when some of the group members are significantly more sophisticated than others regarding psychosocial aspects of clinical care. Problems might arise if this issue is not addressed when there is a mix of experienced practitioners and trainees. Sometimes, a problem occurs when a participant takes the part of the expert in a way that is dominating or demeaning to others. If such a situation is not dealt with, it can have a disruptive effect on the process.

A variety of challenges can affect attendance. For instance, those who are salaried employees, whether in the public or private sector, may have difficulty getting their supervisors to support participation unless they can convey effectively the usefulness of their involvement with COR. Another factor that may affect attendance is the size of the COR group. Information obtained from the projects suggests a trend in the direction of groups somewhat larger than the 10 to 12 members (including moderators) originally envisaged. This probably occurs for a variety of reasons such as interest in being inclusive and desire to offset inevitable absences of some members at certain times. Although it appears as if the larger groups may have more peripheral participants, they seem to have done well with them. Nonetheless, the possibility of a dilution factor is something to keep in mind.

Evaluation information supports further development of the COR concept. Nonetheless, it would seem worthwhile to obtain, through rigorous study, outcome data that may further validate the approach and provide insights to strengthen what one participant has characterized as, “the best method of continuing medical education.”

COMMENT

It is essential that attention to mental health be an integral part of primary health care for children and adolescents, not only to assist early identification of mental disorders and begin the process of intervention, but also to provide a trusted wellness system that can promote positive psychosocial development and serve as a key primary prevention resource. These themes are reflected in Healthy Children 2000: National Health Promotion and Disease Prevention Objectives Related to Mothers, Infants, Children, Adolescents, and Youth; in Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents; and in the new mental health classification system geared particularly to the needs of primary care providers who serve children, adolescents, and their families.

Experience to date points to the COR group as a useful tool for addressing psychosocial issues in primary care. Its potential may be more fully realized by applying this approach more widely, even as further assessment is pursued. A natural extension
would be to explore the applicability of this approach in new situations and with different group compositions. Hopefully, this could expand the contribution of COR to the continuing education and training of health care professionals who serve children, adolescents, and their families.

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