Foreword

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During the 19th and early 20th centuries, medical care often focused on the health of women and children, with concerns about feeding and hygiene. Immunizations were few and breastfeeding was prevalent. Medical education often followed an apprenticeship model.

After the Flexner report in 1910,[1] the focus of medical schools and care changed dramatically. Education took place at centers of learning in which scholarly biomedical research defined the core of the curriculum. Schools without an academic focus closed, and community health centers were viewed as sites for health care for the poor and indigent. Medical education changed its emphasis to basic science. Although all these changes certainly elevated the quality of medical care and scientific advancement, the relevance of medical education to ultimate practice seemed to waiver.

Over the years, there have been attempts to restore practicality to medical education and increase resident involvement in the community. In the late 1960s, federally funded children and youth programs were developed. As a pediatric resident in New York City, I visited settlement houses and welfare hotels to bring health care and medical advice into the community. I am still in contact with colleagues who were fellows in community pediatrics. Such programs were scattered throughout the United States, and their educational experiences were not replicated in a systematic manner. It was not until 1978 when the Task Force on the Future of Pediatric Education brought home the message that residency training was not always relevant to pediatric practice, and many of the conditions children faced were not addressed during the training years.[2] "New" morbidities were defined, although children had faced many of these conditions for a long time; education about the conditions just had not been incorporated into the medical curriculum. Adolescent health, child development, and behavioral pediatrics became important topics. The Residency Review Committee for Pediatrics first made exposure to such areas desirable and then made them a requirement. Continuity clinic, rather than being "hit or miss," evolved into a structured longitudinal experience for residents, with a defined panel of patients. Along the same lines, the Residency Review Committee ultimately increased the amount of time in the ambulatory setting to 50%, and experience in community pediatrics became a requirement, as well.

Novel approaches to implementing these requirements appeared on the academic radar screen. Although some training programs had an abundance of patients to meet the continuity clinic needs of residents within the principal training site, other programs met patient needs and requirements for an expanded outpatient educational experience through the development of pediatric education in community settings. In 1996, the Ambulatory Pediatric Association partnered with the American Academy of Pediatrics and the University of Massachusetts School of Medicine, along with a number of federal agencies, to encourage this model across many programs. The Ambulatory Pediatric Association also was helpful in developing educational guidelines and goals and objectives for these community-based primary care experiences.

The American Academy of Pediatrics has taken a key role in promoting community pediatrics, ie, concern with child health at the community level. Perhaps foremost is its Community Access to Child Health program. Although the program has multiple aspects, fostering resident involvement in community-based child health initiatives is a notable component. A review of the titles of funded resident projects (eg, Residents Reaching Out: Helping Teens of East County, Transitioning the Care of Adolescent Patients, Toward a Medical Home for an Itinerant Population) is a testimony to the commitment of residents to improving the health care of those they serve.

Residency education has changed dramatically over the past few years. There are fewer hours during which to learn but more information to assimilate. Physical examination sometimes seems superfluous in the face of technology that can precisely define anatomy and function. Time constraints sometimes limit attending teaching, and opportunities to learn about critical thinking may be shortchanged.

The Accreditation Council on Graduate Medical Education, along with the American Board of Medical Specialties, has decided to focus on competence rather than process. Six specific areas in which residents as well as practitioners should demonstrate

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and maintain competence have been delineated. Although the notion is intrinsically logical and very appealing, measuring competence and demonstrating that health care and patient safety are improved using these modalities remains challenging. We may create more output, but we have to demonstrate that we have changed the outcome.

One critical challenge is to make certain that we do not get trapped in the "tyranny of the or," with which some important educational experiences are sacrificed to make room for others. We must ensure that health care professionals acquire and maintain the knowledge, skills, and attitudes needed to care for patients, their families, and their communities. Understanding our patients within the context of their micro- and macrocommunities can help us ensure this outcome.

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