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Pediatricians' Perspectives Regarding Community Child Health: Training, Involvement, and Expectations According to Age

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ABSTRACT

OBJECTIVE. There are increasing opportunities for pediatricians to promote children's health through community involvement during and after residency training. Little is known about whether younger relative to established pediatricians have different experiences regarding community activities. In this study we examined whether pediatricians' training, perspectives, and involvement in community activities vary by age.

METHODS. Eight hundred seventy-six pediatricians participated in a national, random-sample, mailed periodic survey of US members of the American Academy of Pediatrics in 2004 (response rate: 58%). χ^2 statistics and median tests were used to measure associations of age (≤ 34 , 35–39, 40–50, and ≥ 51 years) with training, perspectives, and involvement.

RESULTS. Younger pediatricians reported more training in community child health during and before residency but were less likely to be involved currently (37.9% for ≤ 34 years, 44.4% for 35–39 years, 46.2% for 40–50 years, 48.3% for ≥ 51 years). They were more likely to report that their current involvement was too little versus just right or too much (81.3%, 73.5%, 60.7%, and 47.1%, respectively). Younger pediatricians were more willing to spend ≥ 1 hour/month on community child health activities (95.0%, 91.2%, 89.7%, and 85.4%, respectively). Younger versus older pediatricians were more likely to sense moderate or greater responsibility for improving children's health in their community (83.6%, 77.2%, 76.7%, and 70.2%, respectively) and expected their community work to increase during the next 5 years (80.0%, 67.5%, 59.7%, and 40.1%, respectively). Age findings persisted when adjusted for gender.

CONCLUSIONS. Although practice constraints may limit community involvement, younger pediatricians anticipated growing participation in community activities. Longitudinal studies are needed to determine whether such expectations are realized.

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Key Words

community pediatrics, workforce, age

Abbreviations

AAP—American Academy of Pediatrics
PS—periodic survey

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MANY PEDIATRIC RESIDENCY programs now provide didactic and experiential training in community pediatrics. Solomon et al¹ reported that in 2002, 28% of programs provided training in 0 to 3 community settings, 41% in 4 to 6 settings, and 31% in ≥ 7 activities. In addition, many provided didactic education on various community health topics and exposed residents to communicating with elected officials, participating on longitudinal projects, conducting research in the community, and, to a lesser degree, providing legislative testimony.

Although the pediatric Residency Review Committee mandated training in child advocacy in 1991, core competencies in community pediatrics have not been adopted universally. Wright et al² used a modified Delphi process to develop a set of objectives for a resident advocacy curriculum. Rezet et al³ identified community pediatrics competencies and learning objectives, cross-referenced to the Accreditation Council for Graduate Medical Education competencies, that residents are expected to achieve. Despite lack of consensus on curricular content, most residency programs offer related community pediatrics training¹; however, it is unclear whether pediatricians who were trained more recently have more skills or more favorable perspectives than more established pediatricians.

The objective of this study was to examine whether pediatricians' training, perspectives, and involvement in community activities vary by age. We hypothesized that younger physicians relative to older physicians would report more training during residency, less current involvement, and comparable senses of responsibility for improving child health in their communities. These assumptions are based on the growing emphasis of community pediatrics in residency training, conflicting demands of family responsibilities and of establishing practices and/or completing training in the early years after completing residency, and a shared sense of responsibility for children's health, regardless of age.

METHODS

Periodic Survey

The American Academy of Pediatrics (AAP) conducts periodic surveys (PSs) 3 to 4 times per year on topics of importance to pediatricians. Each survey uses a unique random sample of members of the AAP. The 2004 PS (PS 60) included questions on involvement in community child health, including a global question asking participants to indicate whether in the past 12 months they "participated in a professional capacity in any activities that promote child health" in their community. The surveys also included a separate question inquiring about involvement in 19 individual activities (and other category) and whether participation was volunteer or paid. All participants further identified their use of 8 strategies to influence children's health in their home and practice communities, including serving on commu-

nity boards; participating on child health committees; working with a coalition; educating legislators; communicating with media; addressing parent, teacher, or other community groups; working with the local AAP chapter; and voting in state/local elections. All respondents additionally reported on their perspectives regarding community involvement and their use in the past 12 months of 6 skills related to community health activities: locating community resources for individual children, identifying community needs, using population-level data to understand the determinants of children's health, working as a member of an interdisciplinary team to promote children's health in the community, speaking publicly on behalf of children's health, and using computers/Internet to find information about child health policy and related activities. Respondents also described the timing of their participation and training in community activities (eg, before medical school, during medical school, during residency, during fellowship training, since completing training).

Survey content was informed by a national advisory group with expertise in community pediatrics, by review by members of the AAP Community Pediatrics Action Group and the Council on Community Pediatrics, and review of similar PS questions asked in 1989 and 1993. This survey was an 8-page self-administered questionnaire sent to 1829 active members. The original mailing and 5 follow-up mailings to nonrespondents were conducted from April through October 2004. After the first and fifth mailings, an e-mail reminder was sent to nonrespondents with e-mail addresses, and a postcard reminder was sent to those without (68% and 32% of nonrespondents, respectively). We received a total of 1053 completed questionnaires for a response rate of 57.6%.

Data Analysis

Data analysis was conducted to examine the relationship between age and involvement in community child health activities. Analysis included postresidency pediatricians and excluded residents ($n = 160$) and pediatricians with a Specialty Fellow designation ($n = 12$) in the AAP membership database as well as 5 respondents who did not provide age information. The final sample included 876 pediatricians (83.2% of respondents).

χ^2 statistics were used to assess differences according to age in demographic and practice characteristics, community child health perspectives, and participation in community child health activities. Median test analyses (Kruskal-Wallis) also were used to compare skill level in community child health activities according to age category. Age analyses were adjusted for the effect of gender. For the purposes of analysis, 4 age categories were constructed: ≤ 34 , 35 to 39, 40 to 50, and ≥ 51 years). The age range for the youngest category (≤ 34 years) was identified, as a proxy, to capture the experiences of pediatricians within their first 5 years out of residency.

TABLE 1 Personal and Employment Characteristics According to Age

| Characteristic | Total (N = 876), n (%) | Age, n (%), y | | | |
|---|------------------------------|------------------|--------------------|--------------------|------------------|
| | | ≤34 (n = 141) | 35–39 (n = 164) | 40–50 (n = 295) | ≥51 (n = 276) |
| Gender ^a | | | | | |
| Male | 420 (47.9) | 46 (32.6) | 58 (35.4) | 133 (45.1) | 183 (66.3) |
| Female | 456 (52.1) | 95 (67.4) | 106 (64.6) | 162 (54.9) | 93 (33.7) |
| Hispanic origin | | | | | |
| Yes | 58 (6.7) | 8 (5.8) | 11 (6.9) | 27 (9.4) | 12 (4.4) |
| No | 802 (93.3) | 131 (94.2) | 149 (93.1) | 260 (90.6) | 262 (95.6) |
| Race/ethnicity | | | | | |
| White ^a | 560 (74.4) | 91 (75.8) | 84 (60.0) | 190 (77.2) | 195 (78.9) |
| Black/African American | 25 (3.3) | 4 (3.3) | 9 (6.4) | 7 (2.8) | 5 (2.0) |
| Asian ^b | 134 (17.8) | 20 (16.7) | 37 (26.4) | 39 (15.9) | 38 (15.4) |
| Native Hawaiian ^b | 7 (0.9) | 3 (2.5) | 3 (2.1) | 1 (0.4) | 0 (0.0) |
| American Indian | 3 (0.4) | 1 (0.8) | 1 (0.7) | 0 (0.0) | 1 (0.4) |
| Other | 25 (3.3) | 1 (0.8) | 7 (5.0) | 9 (3.7) | 8 (3.2) |
| Marital status ^a | | | | | |
| Married | 765 (87.8) | 110 (78.6) | 148 (90.2) | 256 (87.7) | 251 (91.3) |
| Single | 70 (8.0) | 26 (18.6) | 15 (9.1) | 20 (6.8) | 9 (3.3) |
| Widowed/separated/divorced | 36 (4.1) | 4 (2.9) | 1 (0.6) | 16 (5.5) | 15 (5.5) |
| Children <18 y in household ^a | | | | | |
| Yes | 514 (58.9) | 64 (45.7) | 130 (79.3) | 244 (83.3) | 76 (27.5) |
| No | 359 (41.1) | 76 (54.3) | 34 (20.7) | 49 (16.7) | 200 (72.5) |
| Youngest child ≤5 y ^a | 250 (48.4) | 60 (92.3) | 112 (86.2) | 74 (30.1) | 4 (5.3) |
| Primary employment setting ^b | | | | | |
| Solo or 2-physician practice | 123 (14.4) | 9 (6.4) | 18 (11.3) | 42 (14.5) | 54 (20.3) |
| Pediatric group/multispecialty/staff HMO | 417 (48.8) | 64 (45.7) | 82 (51.6) | 117 (50.9) | 124 (46.6) |
| Medical school | 99 (11.6) | 22 (15.7) | 10 (6.3) | 36 (12.5) | 31 (11.7) |
| Nongovernment/government hospital or clinic | 132 (15.4) | 33 (23.6) | 29 (18.3) | 33 (11.4) | 37 (13.9) |
| Other ^c | 83 (9.8) | 12 (8.6) | 20 (12.5) | 31 (10.7) | 20 (7.5) |
| Community setting for practice | | | | | |
| Urban, inner city | 180 (21.5) | 35 (25.4) | 34 (22.1) | 50 (17.6) | 61 (23.3) |
| Urban, non-inner city | 246 (29.4) | 40 (29.0) | 43 (27.9) | 90 (31.7) | 73 (27.9) |
| Suburban | 307 (36.6) | 48 (34.8) | 53 (34.4) | 114 (40.1) | 92 (35.1) |
| Rural | 105 (12.5) | 15 (10.9) | 24 (15.6) | 30 (10.6) | 36 (13.7) |
| Employment status ^a | | | | | |
| Full-time | 676 (77.2) | 115 (81.6) | 119 (72.6) | 223 (75.6) | 219 (79.3) |
| Part-time | 160 (18.3) | 23 (16.3) | 38 (23.2) | 64 (21.7) | 35 (12.7) |
| Other ^d | 40 (4.6) | 3 (2.1) | 7 (4.3) | 8 (2.7) | 22 (8.0) |
| Percentage of time spent in general pediatrics ^b | | | | | |
| <50% of time | 242 (27.6) | 44 (31.2) | 31 (18.9) | 82 (27.8) | 85 (30.8) |
| ≥50% | 634 (72.4) | 97 (68.8) | 133 (81.1) | 213 (72.2) | 191 (69.2) |

Five age responses are missing. HMO indicates health maintenance organization.

^a $P < .01$.

^b $P < .05$.

^c Includes nonprofit community health center (CHC) and other.

^d Includes retired, semiretired, not in practice, or not active.

This is consistent with graduating residents' mean age being 32 years⁴⁻⁶ and 88% of residents in the United States completing residency training at ≤34 years (K.G.O., unpublished data). In general, 5 to 10 years are required after residency to become established in pediatric practice and to develop relationships in the community.⁷

For assessing potential response bias in 2004, comparisons between respondents and nonrespondents were conducted for several demographic variables. No significant differences were found between respondents and nonrespondents for mean age (43.7 years) and region of country (24.5% Northeast, 21.5% Midwest,

33.4% South, and 20.7% West). More respondents were female (53.9% vs 46.6%; $P < .05$).

Analyses were conducted by using SPSS 11.5 (SPSS Inc, Chicago, IL). Human-subjects approval was obtained from the AAP Institutional Review Board and the Committee on Human Research at Johns Hopkins Bloomberg School of Public Health.

RESULTS

Respondent Characteristics

Demographic and practice characteristics of respondents were compared according to age (Table 1). A greater

TABLE 2 Involvement in Community Child Health Activities in Past 12 Months According to Age

| Parameter | Total (N = 876), n (%) | Age, n (%), y | | | |
|---|------------------------------|------------------|--------------------|--------------------|------------------|
| | | ≤34 (n = 141) | 35–39 (n = 164) | 40–50 (n = 295) | ≥51 (n = 276) |
| Participate in community activities to promote child health | | | | | |
| Yes | 385 (45.1) | 53 (37.9) | 71 (44.4) | 133 (46.2) | 128 (48.3) |
| No | 468 (54.9) | 87 (62.1) | 89 (55.6) | 155 (53.8) | 137 (51.7) |
| Payment in community activities ^a | | | | | |
| Not paid (volunteer) | 306 (79.7) | 46 (86.8) | 55 (79.7) | 114 (85.1) | 91 (71.1) |

^a Among subset of respondents who reported community child health activity participation (valid percentages reported); *P* < .05.

percentage of respondents who were ≤50 years were female, whereas more male respondents were represented among those who were ≥51 years. There were no age differences in racial/ethnic distribution. Approximately half of respondents were working in pediatric group or health maintenance organization practices, and more than half were located in urban settings. Older pediatricians were more commonly in solo or 2-physician practices compared with young pediatricians. More than one quarter of all respondents spent less than half of their time in general pediatrics, and pediatricians in the youngest (through 34 years) and oldest (≥51 years) age categories more frequently indicated this time distribution.

Participation in Community Child Health

Table 2 highlights involvement in community child health activities by the 4 age categories. Participation in community child health tended to be least frequent in the youngest age group (37.9% for ≤34 years, 44.4% for 35–39 years, 46.2% for 40–50 years, and 48.3% for ≥51

years; *P* = .51). The majority of respondents indicated that their community involvement is only on a volunteer basis, with the youngest begin most likely to volunteer (86.8% for ≤34 years, 79.7% for 35–39 years, 85.1% for 40–50 years, and 71.1% for ≥51 years; *P* < .05).

There were age differences in the timing of participation in community child health activities during the course of medical training. More young pediatricians compared with older pediatricians indicated involvement in the early part of their career, including before (68.2%, 59.3%, 43.0%, and 26.9%, respectively; *P* < .01) and during medical school (80.3%, 71.1%, 46.5%, and 36.8%, respectively; *P* < .01). In addition, a greater percentage of young pediatricians participated in community child health training in residency programs (74.2% for ≤34 years, 58.5% for 35–39 years, 51.3% for 40–50 years, and 38.3% for ≥51 years; *P* < .001); however, pediatricians in the older age groups reported more involvement since completing residency than young pediatricians (36.4% for ≤34 years, 56.3% for 35–39

TABLE 3 Perspectives on Involvement and Responsibility for Child Health According to Age

| Parameter | Total (N = 876), n (%) | Age, n (%), y | | | |
|--|------------------------------|------------------|--------------------|--------------------|------------------|
| | | ≤34 (n = 141) | 35–39 (n = 164) | 40–50 (n = 295) | ≥51 (n = 276) |
| Current level of involvement in community child health activities ^a | | | | | |
| Too little | 536 (62.1) | 113 (81.3) | 119 (73.5) | 176 (60.7) | 128 (47.1) |
| Just right | 324 (37.5) | 26 (18.7) | 43 (26.5) | 114 (39.3) | 141 (51.8) |
| Too much | 3 (0.3) | 0 (0.0) | 0 (0.0) | 0 (0.0) | 3 (1.1) |
| View of child health responsibility ^b | | | | | |
| Very responsible | 283 (32.8) | 49 (35.0) | 58 (35.8) | 89 (30.5) | 87 (32.5) |
| Moderately responsible | 371 (43.0) | 68 (48.6) | 67 (41.4) | 135 (46.2) | 101 (37.7) |
| A little responsible | 195 (22.6) | 23 (16.4) | 36 (22.2) | 66 (22.6) | 70 (26.1) |
| Not at all responsible | 13 (1.5) | 0 (0.0) | 1 (0.6) | 2 (0.7) | 10 (3.7) |
| Time willing to spend in child health activities, h/mo ^a | | | | | |
| >5 | 93 (10.8) | 10 (7.1) | 13 (8.2) | 26 (8.9) | 44 (16.4) |
| 4–5 | 84 (9.8) | 20 (14.2) | 13 (8.2) | 31 (10.6) | 20 (7.5) |
| 1–3 | 435 (50.6) | 89 (63.1) | 79 (49.7) | 149 (51.0) | 118 (44.0) |
| <1 | 158 (18.4) | 15 (10.6) | 40 (25.2) | 56 (19.2) | 47 (17.5) |
| 0 | 90 (10.5) | 7 (5.0) | 14 (8.8) | 30 (10.3) | 39 (14.6) |
| Expectation of community work in next 5 y ^a | | | | | |
| Increase | 501 (58.3) | 112 (80.0) | 108 (67.5) | 173 (59.7) | 108 (40.1) |
| Stay the same | 336 (39.1) | 28 (20.0) | 48 (30.0) | 115 (39.7) | 145 (53.9) |
| Decrease | 22 (2.6) | 0 (0.0) | 4 (2.5) | 2 (0.7) | 16 (5.9) |

^a *P* < .01.

^b *P* < .05.

TABLE 4 Skills Used in Participating in Community Child Health Activities in the Past Year According to Age

| Activity | Total (N = 876), n (%) | Age, n (%), y | | | |
|--|------------------------------|------------------|--------------------|--------------------|------------------|
| | | ≤34 (n = 141) | 35–39 (n = 164) | 40–50 (n = 295) | ≥51 (n = 276) |
| Locate resources for individual children ^a | 564 (68.4) | 96 (69.1) | 114 (73.5) | 191 (68.2) | 163 (64.9) |
| Identify community needs ^b | 248 (30.8) | 26 (19.4) | 42 (28.2) | 85 (31.3) | 95 (37.8) |
| Use population-level data to understand the determinants of children's health | 201 (25.2) | 32 (24.1) | 27 (18.0) | 68 (25.0) | 74 (30.5) |
| Member of a team to promote child health | 246 (30.4) | 34 (25.2) | 38 (25.5) | 89 (32.2) | 85 (34.0) |
| Speak publicly on behalf of children's health ^b | 227 (27.8) | 31 (22.8) | 33 (21.6) | 85 (30.9) | 78 (31.0) |
| Use computers and Internet to find information about child health policy and related activities ^a | 550 (67.0) | 109 (79.0) | 108 (70.6) | 180 (65.0) | 153 (60.5) |

^a *P* < .01.^b *P* < .05.

years, 78.1% for 40–50 years, and 87.6% for ≥51 years). Age differences in the timing of training persisted when analyses were adjusted for gender.

Pediatricians chose varying strategies in their community child health promotion activities. Overall, most respondents used voting in state and local elections (69.7%) and addressing community groups (48.7%) as their more common strategies rather than working as a coalition member (8.4%) or serving on a community organization board (17.0%). Pediatricians in the oldest and youngest age groups educated legislators (26.9% for ≤34 years, 11.5% for 35–39 years, 19.9% for 40–50 years, and 33.3% for ≥51 years; *P* < .01) and worked with their local AAP chapters (21.2% for ≤34 years, 10.7% for 35–39 years, 14.5% for 40–50 years, and 23.1% for ≥51 years; *P* < .01). Conversely, more pediatricians between 35 and 50 years of age focused on addressing parent, teacher, or other community groups (46.2% for ≤34 years, 59.5% for 35–39 years, 52.0% for 40–50 years, and 40.0% for ≥51 years; *P* < .01).

The community child health settings where pediatricians were engaged (health, school, government, or nonprofit) did not vary by age, with 1 exception. Older pediatricians were more involved with nonprofit organizations (eg, Children's Defense Fund, March of Dimes) than younger pediatricians (11.3% for ≤34 years,

11.6% for 35–39 years, 16.3% for 40–50 years, and 20.7% for ≥51 years; *P* < .05).

Community Child Health Perspectives

There were key age differences in perspectives toward involvement in community child health activities (Table 3). A greater percentage of young pediatricians reported that their current level of participation is too little, whereas more than half of pediatricians in the oldest age category (≥51 years) believed that their involvement was "just right." Young pediatricians also expected an increase in their community work in the next 5 years, whereas fewer pediatricians who were older than 40 years anticipated an increase (81.3% for ≤34 years, 73.5% for 35–39 years, 60.7% for 40–50 years, and 47.1% for ≥51 years; *P* < .01). Younger versus older pediatricians were more likely to sense moderate or greater responsibility for improving the health of children in their community (83.6% for ≤34 years, 77.2% for 35–39 years, 76.7% for 40–50 years, and 70.2% for ≥51 years; *P* < .05). Age differences persisted after adjustment for gender.

Skills and Training in Community Child Health

Tables 4 and 5 describe use of 6 skills in participating in community health activities and reported skill levels ac-

TABLE 5 Moderate/High Skills Used in Participating in Community Child Health Activities According to Age

| Activity | Total (N = 876), n (%) | Age, n (%), y | | | |
|--|------------------------------|------------------|--------------------|--------------------|------------------|
| | | ≤34 (n = 141) | 35–39 (n = 164) | 40–50 (n = 295) | ≥51 (n = 276) |
| Locate resources for individual children ^a | 397 (56.6) | 51 (44.0) | 73 (53.3) | 138 (56.8) | 135 (65.5) |
| Identify community needs ^b | 167 (29.7) | 14 (17.5) | 24 (23.1) | 62 (31.5) | 67 (37.0) |
| Use population-level data to understand the determinants of children's health | 156 (28.1) | 20 (23.5) | 24 (23.3) | 52 (26.3) | 60 (35.3) |
| Member of a team to promote child health | 253 (43.9) | 26 (30.6) | 48 (44.9) | 84 (41.0) | 95 (53.1) |
| Speak publicly on behalf of children's health ^b | 293 (50.7) | 35 (41.7) | 44 (41.5) | 117 (56.0) | 97 (54.2) |
| Use computers and Internet to find information about child health policy and related activities ^a | 421 (60.2) | 85 (70.2) | 89 (66.9) | 141 (60.3) | 106 (50.2) |

Significance testing using Kruskal-Wallis test for medians.

^a *P* < .01.^b *P* < .05.

according to age. Using the Internet to find information about child health policy was more common among younger pediatricians, whereas working to identify community health needs was cited less commonly. Median test analyses revealed that younger pediatricians reported a higher skill level in using the computers/Internet to find information about child health policy ($P < .01$), whereas older pediatricians noted more skill in locating resources for children ($P < .01$), speaking publicly on behalf of child health ($P < .05$), and identifying community needs ($P < .05$). Age differences in skills with regard to computers, local resources, and identifying community needs persisted when adjusted for gender.

Training in community child health also differed according to age. Many (44%) respondents had never received formal training at any point in their medical career, and the most common time for training was during residency (39.1%). Formal training during medical school (43.0% for ≤ 34 years, 52.6% for 35–39 years, 32.0% for 40–50 years, and 22.4% for ≥ 51 years; $P < .01$) and residency (63.4% for ≤ 34 years, 54.7% for 35–39 years, 29.9% for 40–50 years, and 20.0% for ≥ 51 years; $P < .01$) was more frequently cited among younger pediatricians, whereas older pediatricians indicated receipt of training after residency (5.4% for ≤ 34 years, 7.4% for 35–39 years, 25.9% for 40–50 years, and 36.0% for ≥ 51 years; $P < .01$). Again, findings of differences in training according to age were independent of gender.

DISCUSSION

Traditionally, work in the community and particularly work that is aimed at policy change at a systems level generally has been done by more established physicians, based on their years of experience in the community and their increasing understanding of the complex interplay of systems, community, and family factors on the lives of children.⁸ In recent years, there has been a growing interest among young physicians and among the faculty in residency training programs to introduce the knowledge, skills, and attitudes necessary to address community- and systems-level problems earlier in the careers of physicians.^{5,9–12} A driving force for the creation of the Dyson Community Pediatrics Initiative was the notion that advocacy in pediatrics at the community level would be far more effective if it were an integral part of a pediatrician's work throughout his or her career than if it were engaged in only at the culmination of the career.¹³

In these analyses, pediatricians reported more training during medical school and residency, greater expectations for increased future involvement, and less involvement in the past year by the youngest pediatricians. The observed differences in perspectives regarding and engagement in community activities

suggest a need to develop age-specific strategies for encouraging increased participation in community child health.⁷ For example, younger pediatricians may benefit from senior colleagues' introducing them to community leaders, highlighting local resources, identifying community needs, and providing networking opportunities. More established pediatricians may benefit from training in specific skills to which they have not been previously exposed, such as computer-related activities and the additional human resources of younger pediatricians who also are committed to improving the lives of children.

Although all pediatricians balance work and personal commitments with community involvement, opportunities for younger pediatricians may need to recognize places and organizations with which young parents come into contact to facilitate their involvement in ways that are particularly meaningful to the needs of their own families. Organizations that are interested in promoting involvement of those in the middle age group may find that a mix of strategies is needed. For all groups, it is likely that pediatricians will continue to select multiple venues in which to be engaged, based on life experiences, personal preferences, and political climate.

Differences observed according to age also may reflect generational differences with those in the youngest age group, a product of generation X, more concerned about work-life balance¹⁴ and perhaps, in combination with challenges of establishing careers and families, being less willing to engage at the current time in community activities. More established pediatricians, born during the baby boomer and traditional eras,¹⁴ may be more willing to work longer hours without enhanced remuneration and be more service oriented. To address this possibility, we assessed participation in community activities among those aged 40 to 50 years in this survey, aged 29 to 39 years in the 1993 survey, and aged 29 to 35 years in the 1989 survey and found comparable percentages of 42%, 49%, and 46%, respectively, suggesting stable levels of involvement among the cohort over time; however, within each PS, we also observed increasing involvement in community activities with increasing age, suggesting that generational differences alone do not account for the observed findings; rather, younger pediatricians likely require time to establish themselves professionally and gain credibility in their local communities before engaging in community activities.^{4,15} In both the 2004 and 1993 surveys, greater percentages of younger pediatricians reported that their current level of involvement was too little, recognizing a desire for increasing involvement.

Several limitations should be noted. First, self-report may lead to overestimations of community involvement, although we have no reason to suspect that this varies by age. It is possible that younger pediatricians, with more training in residency and not having entered the work

world beyond training, inflate their anticipated future involvement. Second, enhanced exposure to community pediatrics may increase social desirability bias, with younger pediatricians reporting but not truly believing that they have greater responsibility than their older colleagues. Third, we focused on population-based rather than individual patient-level skills in this national survey of pediatricians; however, other assessment tools assess quality of care with regard to medical home attributes and primary care. Fourth, it is possible that older pediatricians do not report receipt of formal training during residency because of recall bias; however, our finding of increased training for those who more recently completed residency is consistent with increased exposures to community pediatrics reported by third-year residents surveyed from 1997 to 2002.⁵ Finally, the survey response rate was 58%, although this level of participation is consistent with other national surveys of physicians, and respondent bias has not been observed in other PSs.¹⁶

Whether generational perspectives ultimately influence pediatricians' involvement in community activities is unclear. From 1997 to 2002, third-year pediatric residents reported enhanced quality of training regarding child advocacy and assessing the needs of their community as they increasingly were exposed to community sites, including schools, child care centers, public health departments, and community health centers.⁵ It is possible that increased skills and exposures will overcome potential generational tendencies for less involvement; however, with younger physicians increasingly working in salaried positions in group practices, ability to participate in community activities may require engagement outside work responsibilities if such activities are not supported and valued by employers or paid for by other sources. Although there is decreased involvement by younger pediatricians, this largely reflects a decline in paid activities. A separate article (C.S.M., K.G.O., H.G., A.C., C. A. Aligne, MD, MPH, M. D. Kogan, PhD, and D. Tayloe, MD, unpublished data) discussed time trends with regard to community child health activities and documented that during the past 2 decades, there was a decline in pediatrician involvement in government and philanthropically sponsored paid opportunities for community activities.

CONCLUSIONS

Pediatricians' training, perspectives, and involvement in community child health activities vary by age. Although younger pediatricians report less current involvement, they also report receiving more training during and before residency and believe that their current level of involvement is insufficient. Prospective longitudinal studies, such as that being conducted as part of the national evaluation of the Dyson Community Pediatrics Training Initiative, are needed to address whether

greater exposures to community training during residency and expectations for greater involvement translate into enhanced involvement once pediatricians are established in their careers.

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THE STATE CHILDREN'S HEALTH INSURANCE PLAN AND THE WAR ON (EXPENSIVE) DRUGS

“The reauthorization of the State Children’s Health Insurance Program (SCHIP), created in 1997 to cover children from lower-income families who make too much to qualify for Medicaid, is up for renewal this fall. Tucked into page 414, section 904 of the House bill is a provision to spend more than \$300 million to establish a new federal ‘Center for Comparative Effectiveness’ to conduct government-run studies of the economic considerations that go into drug choices. The center will initially be funded through Medicare but will soon get its own ‘trust fund.’ The aim is to arm government actuaries with data that proponents hope will provide ‘scientific’ proof that expensive new drugs are no better than their older alternatives. The trick is to maintain just enough credibility around the conduct of these trials to justify unpopular decisions not to pay for newer medicines. While there’s nothing inherently wrong with this sort of fiscally minded clinical research, Medicare is no ordinary payer: It dictates decisions made in the private market. So as the government begins tying its own payment decisions to the results of its own studies, there’s a great temptation to selectively interpret data and arbitrarily release results. Clearly, this obvious conflict of interest demands even more outside scrutiny and transparency than has been the usual fare when it comes to government research. The inherent complexity and limitations of conducting these sorts of ‘comparative’ drug trials also need to be carefully considered before policy makers rush to tie sweeping payment choices to results of single studies. If not, there’s a real risk that faux science and limited findings will be used to set rigid payment policies that will arbitrate access to new treatments for the entire health-care market.”

Scott Gottlieb. *Wall Street Journal*. August 30, 2007

Editor’s Note: At first this looks like a good idea, but later you realize it can be a very bad idea.

Noted by JFL

Pediatricians' Perspectives Regarding Community Child Health: Training, Involvement, and Expectations According to Age

Cynthia S. Minkovitz, Karen G. O'Connor, Holly Grason, Judith S. Palfrey, Anita Chandra and Thomas F. Tonniges

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