

RATING PEDIATRIC HOUSE OFFICER PERFORMANCE. C.Z. Margolis and C.D. Cook, Dept. Ped., Yale Med. School, New Haven.

The results of a simple method for evaluating pediatric house officer performance and for establishing criteria for the evaluation are presented. House officer ratings are compared to their intern matching plan rankings and their Pediatric Board "pre-test" or regular scores. Finally, a pediatric faculty's educational objectives are compared to performance criteria. A performance rating between 1 (excellent) and 4 (unsatisfactory), which consisted of mean scores of 12 faculty members, was calculated for each of 27 house officers. Interrater reliability was .63. The mean house staff rating was $1.95 \pm SD .50$ (range 1.16 to 3.15). Correlation coefficients of four and fifteen month reevaluations with the original evaluation were .938 and .888. Six criteria of performance, compassion, knowledge, dependability, critical attitude, teamwork and efficiency, were independently listed by a majority of faculty members as the basis for their evaluation. Ratings correlated neither with Pediatric Board scores nor with intern matching plan rankings. Though the faculty viewed cognitive skills as objectives, they expected competent clinical performance to result from house staff training.

We conclude that total clinical performance can be reproducibly rated, that it is predicted neither by Board scores nor by matching plan rankings, and that both cognitive and non-cognitive criteria for effective performance of a pediatric house officer's job should be clearly stated by a pediatric faculty.

NATIONAL PRIORITIES FOR IMPROVING CHILD HEALTH: RESULTS OF A QUESTIONNAIRE, E.A. Mortimer, Jr. and Charles D. Cook, Joint Council of National Pediatric Societies, c/o Dept. of Ped., Univ. of N. Mexico, Albuquerque.

From May through July, 1973, 283 pediatricians representing 13 subspecialties as well as general pediatrics answered a questionnaire which attempted to obtain (1) their recommended apportionment of new funds for improving child health in the U.S. between care, research and education, and (2) their degree of emphasis on various subdivisions of these major categories of needs. 90% of the respondents were primarily in academic pediatrics and 10% in private practice. The suggested distribution of the hypothetical new funds averaged 43% for care, 32% for research and 25% for education. Under care, the translation of knowledge into practice, and research concerning care delivery were rated highest and screening techniques lowest. Under research, investigation of the relation between diseases affecting children and those affecting adults was considered most important, perinatology next and cardiopulmonary diseases last. Under education, continuing education and training teachers were considered most important in the use of new funds and training clinical specialists least vital. Although a broad view of needs for improving the health of children was requested, most specialists considered their own field most worthy of support.