

The Lead in Peds

Transcript: Season 2, Episode 3 – Health Professions Education Research: Training Better Doctors, Improving Care for Patients

Host: [Nathan Kuppermann, MD, MPH](#)

Guests: [Lanre Falusi, MD, MEd](#); [Priti D. Bhansali, MD, MEd, MBA](#)

Dr. Nathan Kuppermann (00:00):

When people think about becoming a doctor, they often picture medical school, residency, and years of clinical training. But what is sometimes less visible is that education medicine never really ends. Physicians are constantly learning how to incorporate the newest evidence in clinical care, how to communicate with patients and families, how to work in teams, how to respond to challenging situations, how to incorporate new technology into their education and their clinical practices, and how to teach the next generation. And just like clinical care, that education should be studied, measured, and improved.

(00:37):

Today, we're talking about health professions education research, what it is, why it matters, and how it ultimately affects the care children and families receive. This is research that asks how we train better doctors, build better teachers, strengthen communication, address social needs, and prepare healthcare professionals for the complex realities of modern medicine. Welcome to The Lead in Peds, the podcast where we highlight the breakthroughs driving pediatric research and clinical care. I'm Dr. Nate Kuppermann, Chief Academic Officer and Chair of Pediatrics at Children's National. And today I'm joined by two physician leaders in health professions education and pediatric care. Dr. Lanre Falusi is associate professor of pediatrics at George Washington University School of Medicine and Health Sciences and Medical Director of Advocacy Education at Children's National. Her work focuses on advocacy education, community engagement, social drivers of health, and preparing residents to care for children and families beyond the walls of the hospital.

(01:44):

Dr. Prit Bhansali is professor of pediatrics at George Washington University, the director of Children's Academy of Pediatric Educators and Director of Scholarship and Faculty Development in the Division of Hospital Medicine at Children's National. Her work includes scholarship and ongoing professional development for faculty through a variety of academic initiatives, project consultations, and peer observation and feedback. She has done research in areas such as health literacy, screening for social needs, and firearm injury prevention. Prit, Lanre, thank you both so much for being here with us on Leading Peds.

Dr. Priti D. Bhansali (02:22):

Thank you so much for having us.

Dr. Lanre Omolayo Falusi (02:23):

Great to be here.

Dr. Nathan Kuppermann (02:24):

So what I want to ask you is when you went into medicine, we all had these mentors or people that really had a lasting impact on how we care for patients and the practice of medicine. But what I would like to ask the two of you, do you have specific individuals or mentors who really shaped the way you think about education and training educators? And let me start with you, Prit.

Dr. Priti D. Bhansali (02:50):

Yeah, sure. So I've had a lot of great educators over the years. Most of them made learning really fun. The one person that stands out in my mind about mentoring in terms of medical education, health professions education scholarship is actually my former program director at the University of Connecticut School of Medicine. His name is Dr. Edwin Zalneraitis. He's a pediatric neurologist. And when I was his associate program director for the residency program there, he really encouraged me to be innovative and evidence-based, but he also wanted me to take a very scholarly approach to what we were doing so that we could disseminate it with others, whether the outcome was amazing or whether it was not.

(03:32):

The other thing that I thought I got from his mentorship was actually the idea of the importance of partnering with people with different perspectives. I remember this one time I had a study that I wanted to do. I'd gone through the IRB. I was just waiting for approval, and then someone sent out a survey that essentially was very similar to what I was hoping to look into. And initially it was a little disheartened, but he said, "You know what? Why don't you reach out to that person and collaborate with them?" And actually it really strengthened the rigor of what we were doing, made it more generalizable. So I thought those were two big takeaways that I got from him.

Dr. Nathan Kuppermann (04:09):

That's great. How about you, Lanre?

Dr. Lanre Omolayo Falusi (04:11):

So I'd say the first person that comes to mind that was and still is an amazing mentor is Dr. Mary Ottolini, who was our vice chair of education at Children's National some years ago. I came to Children's as a faculty member about 10 years ago after several years of working at a community health center. So at an FQHC, federally qualified health center. I had the fortune of leading education for our physicians and nurses. We had nutritionists and dentists. I had residents, but I don't think I was being very scientific or scholarly in the approach of how we were training people across disciplines.

(04:46):

So when I got to Children's and started working with Mary, she really pushed me to be similarly sort of evidence-based and to think about things more systematically. She also, maybe six months into my coming back to Children's, sent an email to a few people saying, "There's this federal grant available on health professions education. Someone should think about applying." I was like, "Sure." Never written a federal grant in my life. Started working on it halfway through. I was like, "Mary, what is this? I'm 60 pages in and probably another 60 pages to go." And she just really encouraged me to keep trying, and I don't think that I would've jumped into something that I realized as I got into it that was so labor-intensive but worthwhile. And I was able to get my first grant really with her mentorship. So I always think about her and how she was both pushing me, but also very encouraging, providing the resources to be able to get there.

Dr. Nathan Kuppermann (05:41):

We all have those mentors who have this incredible impression on us because there aren't that many of them as opposed to lots of medical students that we've had. And I'll just say mine, I'm a very sort of research oriented pediatric chair, and the mentor that impacted me the most early on was a guy named Alan Jobe. He's retired, he's at University of Cincinnati, but he taught me the importance of words. So I was a second year resident in the neonatal ICU and I was talking about a septic workup and he stopped me. He goes, "Nate, just so you know, you shouldn't call it a septic workup. A septic workup means that you spit on your hands, you run them together, and then you did a spinal tap. What you're doing is an evaluation for sepsis." And it gave me pause, but I think of that to this day. He just taught me about the importance of communication and using the right words in communication. So anyway, it's sort of interesting how we've all had people that have had big impacts on us early on.

(06:46):

So the second thing I just want to ask before we get started is, was there a moment in each of your early careers when you thought, "Wow, there's education out there, but then there's this notion of research or learning about education and the right way to educate and teaching about the right way to educate." When did that moment or was there a moment. Let me start with you, Prit.

Dr. Priti D. Bhansali (07:13):

Yeah, so I think one time that stands out to me, I'm a very curious person, I always have questions, and I remember walking into a room where I was a teaching attending and the family had maybe a newborn. I

was asking them like, "Oh, would it be all right if I could bring in students to come and do a physical exam on your child?" And they were like, "Oh, we had students here last night doing that." I remember thinking that's odd because we don't ask our students at the time to spend the night. And it turned out that they were referring to the physician trainees who were interns and residents. And so I was like, oh wow, if you don't say that you're a doctor and you say you're an intern, then that might mean a number of different things to different people.

(07:57):

And so I was like, oh, I wonder how many times people don't realize that an actual physician in training is taking care of their child. And that was a question that I had. And it was really some of my mentors who was like, you should look at the literature, see what's out there about this, and then see how to go about answering your research questions. So I think it was in the context of doing the teaching where I ended up having a situation where there was a clinical research question that came up to me about education that was like, oh, this can happen in parallel.

Dr. Nathan Kuppermann (08:35):

Great. How about you, Lanre?

Dr. Lanre Omolayo Falusi (08:38):

So I think one moment is, or a number of moments, but sort of leading to the same question where myself and colleagues, we've created these curricula around child poverty, around social drivers of health, and we would go and present our work somewhere. And I noticed a few times I would get a question from someone in the audience saying, "Okay, so you evaluated your curriculum by asking the residents to do X, Y, Z, but did you ask the patients? Have you asked the families, does this work? Are the residents, how's their performance?" And it took me a couple of times of hearing that to realize we really don't, we don't ask them. And also not quite being sure how to ask them, but I figured maybe a few of us could sit down in a room and write up a brief survey and hand that out to families, but is that the right way?

(09:31):

So in talking with survey design experts, community engagement experts, we've gone through a much more systematic and rigorous way to create a survey that families can complete to give us feedback in that sort of way. So I think that question of is everyone at the table to give feedback on our trainees has been, I think, a big turning point for me in thinking about how we assess our education, our training, and being able to bring those folks together makes it much more rich to be able to actually perform that research together.

Dr. Priti D. Bhansali (10:05):

You made me think of one of my fellows who's now a faculty member at Seattle. We were brainstorming about one of his fellow projects about family-centered rounds and teaching practices that happened during family-centered rounds. And the plan was to do qualitative research with this group and that group and

this group. And I was like, "Well, we all should do the qualitative interviews with the families." And so what you're saying is just reminding me of that importance that I think has been overlooked sometimes.

Dr. Lanre Omolayo Falusi (10:34):

And I think that's true. So families and children are at the core of what we do, yet somehow it is sometimes too easy to forget to include them in the research that we do. So it's something that I think we're all trying to get better and really focus on.

Dr. Nathan Kuppermann (10:50):

It's really interesting listening to you guys speak about that because I'm an educator, but I'm not an expert in the research and education like you are, but as a clinical researcher, it's interesting that we've also kind of come around that 20 years ago we would do research with our questions in mind, not really engaging patients and families about what they thought are the important outcomes we studied. But now it's standard now to have family participants to make sure that what we're studying is important to them. And in fact, a whole federal [inaudible 00:11:25], as you know, the Patient Centered Outcome Research Institute, PCORI, is built around that whole notion that really the questions that we should be asking in science in general should be based around what's important to patients and their families, right?

Dr. Lanre Omolayo Falusi (11:38):

Absolutely.

Dr. Nathan Kuppermann (11:38):

It's fascinating. So I'm going to start just with the most basic question is, what does it mean by saying that you do health professions education research or medical education research? Lanre, let me start with you and then I'll go to Prit.

Dr. Lanre Omolayo Falusi (11:54):

We talk a lot about medical education being very physician-centric, but the health professions encompass not just medicine, but nursing and physical therapy and our entire healthcare team. So health professions education is education on how we teach. So it's what are the best ways to teach the learners? How do we teach the faculty educators who are involved? It's research in the education setting, so whether that is in an exam room or in a classroom or in the community, wherever people are learning about health and how to care for patients and communities, very globally speaking is sort of health professions education. So then the research piece is how we figure out what the best ways are. So what are the best practices? What can we learn from the processes of teaching? How do we ensure that the resources are being put in the right way to be able to teach correctly and looking what the outcomes are from our education?

Dr. Priti D. Bhansali (12:57):

Yeah, no, I agree with everything that you just said actually. When you think about research, I think of it as the systematic investigation of any sort of phenomenon to gain more understanding, maybe reach new conclusions. And so when I think about that in the context of education research, generally, it's that applied to the scientific field of how people learn educational methods, educational outcomes, learning context in general, whether they're formal learning contexts, informal learning contexts, whether it's at the individual level, the organizational level, and then to make that a little bit more specific to health professions education, it includes learners or participants in healthcare in that particular context. So it's meant to be just as similar to other types of research in that it's systematic, it reflects the literature that's already been done, it answers a specific research question, it uses rigorous methods, it's ethical and it's intended to be disseminated.

Dr. Nathan Kuppermann (14:00):

I feel that education historically in medicine and maybe in other disciplines as well, I think about it actually when I was in college, the fancy professors weren't the ones that were lecturing to me, they were the TAs and I didn't know how much instruction they received in education, but I think there's this assumption in medical education training, well, people don't just learn how to teach. It's just something that comes naturally or something along those lines. But obviously it's a really important discipline that needs to be nurtured and taught in the right way.

(14:32):

And let me ask you, Prit, this, you raised something in there that as a chair of pediatrics, I think about a lot. Why do you think historically it's been undervalued? And when I say undervalued, for example, the National Institutes of Health, the NIH, that's where researchers get their money to study research. There's no NIH for education research. In a department or health system, there is frequently not money set aside

to train the trainers or to have educators have the time that they need to really promote the discipline of education. But why do you think it's been undervalued?

Dr. Priti D. Bhansali (15:15):

There are organizations that fund education research in medicine and healthcare. The AAMC has grant awards, AHRQ has grant awards. There's many professional associations and foundations that actually do fund health professions education. I think the issue is that unlike biomedical research, which may at some point have some significant funding by a company that stands to profit considerably from looking at a long-term randomized controlled trial, often the funding for health professions education research doesn't really cover time for the educator who is also a clinician to do the research. They actually are often trying to fit this into their other responsibilities and obligations. And so I think it can be challenging for that person to demonstrate outcomes from even a really good project idea.

(16:08):

Also, when you're doing health professions education research, it is hard to trace back from patient outcomes that are downstream. It's very hard in this complex healthcare system to find that one variable and see if it truly impacted the downstream effect. That being said, the converse is really important in that educational interventions, whether they're related to curriculum or whether they're related to assessment measures or something along those lines, they actually have a profound impact downstream because each trainee, each learner, each participant in an educational course, venue, learning event then impacts hundreds of trainees downstream. So it should be valued, but I think sometimes it becomes challenging to do those studies for the reasons I mentioned.

Dr. Nathan Kuppermann (16:58):

It is interesting around education research. In clinical research, we'll do a randomized trial. Intervention A versus intervention B, we see the impact on a specific condition in childhood. In education, the randomized trial, I would imagine it's really hard to do. You do one sort of pedagogy for educating this way and then that way because the outcome ultimately should be how the patients do way downstream. What are the proxies for that? And you're alluding to that somewhat, but you want to elaborate a little bit more on that?

Dr. Priti D. Bhansali (17:33):

Yeah, I mean, so you can do a randomized control trial in health professions education. It's very difficult, just like it would be difficult to do in clinical research. I'm sure that's difficult too. I think that sometimes what I've seen are crossover trials where one team of participants has given curricula, another team of participants is given a different curricula, and then they switch midway through a study period. So there are ways from a quantitative standpoint in quantitative study design to do those types of studies.

(18:07):

But again, if you're looking at patient outcomes as a result of those studies, you can certainly discern if people who are being exposed to these curricula liked it, you can see their satisfaction, you can certainly

see if they have had knowledge gained from a particular educational intervention. It's harder to see behavior change, which is sort of that next level. And then the hardest to see is the final result of all that training. So I think that that is what takes a lot of time. And then again, because of the complexity of healthcare and healthcare training, it can be very hard to backtrack to see, well, was it this or was it that over years?

Dr. Nathan Kuppermann (18:47):

So Lanre, let me, first of all, love to hear your thoughts on it. Why don't you react to that, your thoughts on this?

Dr. Lanre Omolayo Falusi (18:54):

Yeah, no, I wholeheartedly agree. And I think the piece around the types of outcomes that could be proxies I think is where we try to focus. So there are the process outcomes, so whether residents are behaving differently or doing something differently. I've tried, I sort of alluding to what we talked about earlier to, even if I can't say that that child's blood pressure, asthma control test score is different based on the lecture that the resident got, there are ways to get at some types of patient outcomes, if not in a quantitative way, maybe a more qualitative way. So I think there's more work happening around that where families, patients are being interviewed or being brought into the research in more of a qualitative way to assess the outcomes from their standpoint. I think that is helpful.

(19:47):

I do hope that, this does require a lot of resources and funding, that we are able to have more of those very rigorous or gold standard kind of randomized controlled trials within education research with more time. But in the meantime, I do think that the outcomes that we are able to assess, the processes that we are able to follow are rigorous and are meaningful, even if it's not always to the pinnacle that Prit is describing in terms of patient level outcomes.

Dr. Nathan Kuppermann (20:15):

I'm just going to make a shameless plug for both of you guys and to our listeners out there, what you're describing is critical to medicine. It's critical to the way we care for patients, education, how we educate, best ways to educate, and it is underfunded. There is no NIH for funding. So I'm just throwing that out there to the listeners out there if you, this is an area that historically greatly benefits from donors and philanthropies, endowed chairs, because this is a powerful way to help promote best education, which ultimately leads to best patient care and whatnot. But Lanre, let me ask you specifically about your research program and your curricula that you've developed and tell us about the gaps that you've tried to fill with the work that you do. Why don't you tell the viewers?

Dr. Lanre Omolayo Falusi (21:08):

Yeah, so a lot of the curricula that we've built are focused on, as I mentioned, social drivers of health, so access to nutritious foods, housing quality, education, that sort of thing. The gaps that we've seen are one, one in every five children in the United States lives in poverty, higher rates depending on where you live,

that we as a medical or health profession generally have not been able to address that very directly with our education. We also know that most physicians, maybe different other specialties, but most physicians did not grow up in poverty. So there's not even really a lived experience that people can pull from necessarily as they're trying to connect with the family across these issues. So what we've been able to do is to build curricula that focus on not just the definitions of things like poverty, but also what are the historical underpinnings, what are the foundational issues around that, what are the health impacts for a child or for a family or for a community when there are economic strains or historical inequities?

(22:16):

And the goal there is for us to recognize that going back to asthma, so a resident, a student, a nurse can talk about asthma medications, we can prescribe all the asthma medications, but if that child goes back to the home that has mold or has pests, no amount of medication can fix that problem or you can't prescribe your way out of an empty refrigerator. But what we try to teach is how can you partner with families, with government organizations, with community organizations to be able to address those higher level issues even right there in the exam room?

(22:54):

And then I like to say that my sort of hidden job is to get our trainees outside of the hospital. So how do we now get folks into the communities where our patients are living and going to school and where their parents are working so that they can see firsthand what those environments are like that builds empathy, builds better understanding, and I think it makes us better clinicians as a whole.

Dr. Nathan Kuppermann (23:18):

Obviously you guys are strong believers in promoting the growth of educators, but also in health equity and advocacy. And I'm just wondering in health professions education research, how do we incorporate the education around advocacy? We are not taught that in medical school and historically have not been taught that in residency and health equity. And yeah, what are your thoughts about that?

Dr. Lanre Omolayo Falusi (23:44):

I do agree that with every passing year, we have a new cohort of trainees who are more educated, more savvy. So I do think that a lot of, whether it's medical schools or residencies, those who are seeking fellows or nursing schools are doing it more, way more than I had when I was in training.

Dr. Priti D. Bhansali (24:04):

Same.

Dr. Lanre Omolayo Falusi (24:05):

And I appreciate that because then it pushes us to not just stick to the surface level. We do have to get deeper into, again, the history behind these issues or how a child may show up differently in your exam room based on what they're experiencing at home or in their communities.

(24:25):

So to your question of how we teach it, there's no one best way. What we do know is that multimodal learning is a standard. So some of that may be asynchronous, so utilizing technology to maybe teach the basics. So they learn the definitions through an online module or something like that. But then there's also the need for the hands-on experiences. So that's getting folks out into the communities or policy experience where they're going to a hearing or a briefing and writing a policy writeup based on that. And then certainly spending the time with families and learning how to communicate. So how do we bridge across cultures or how do we talk with families with cultural humility is all part of the advocacy.

(25:11):

And lots of frameworks around that too, whether that's individual, community policy, global advocacy or ways that we can train around within a health system or outside of a health system. But yeah, our goal is to try to do it all in various modes of learning, and that's part of our research too, to best figure out what

configuration works best as we assess people's knowledge or changing behaviors or attitudes after they're learning.

Dr. Nathan Kuppermann (25:42):

As you both know, I'm trained as a pediatric emergency physician and we use a lot of simulation for resuscitation, for procedures and such, but that's a pretty narrow view of the use of simulation. And I'm going to ask you, Prit, what in your mind makes simulation such a powerful tool in the pedagogy, the teaching of education?

Dr. Priti D. Bhansali (26:03):

Yeah, so simulation is a great tool in that it allows you to, as a participant in a simulation, make mistakes and to practice in a relatively low risk setting. And so that works really well for the circumstances that you were talking about where you might've been trained on how to resuscitate a patient or do a procedure, but it might be relatively uncommon in day-to-day practice. And so you have this opportunity through simulation to do these things repeatedly if need be. Some of the ways that we're using simulation at Children's National are really innovative and have sort of spanned other aspects of care, including communication.

(26:44):

The two areas that come to mind for me are in addressing microaggressions and then also how to address a situation where there's some verbal escalation and how to appropriately deescalate in those situations. Now, those types of events happen more commonly than perhaps a resuscitation event, but personally, I don't think I received any didactic or specific training on how to handle those situations, but you could argue those are particularly also high risk because that sort of addresses how you go on communicating with colleagues and the patients and families that we take care of. And so again, simulation allows you to make those mistakes, practice, get feedback in, again, a relatively low risk setting.

(27:26):

From the standpoint of simulation as a research tool in education, what I think is great about simulation is that you can standardize your scenario, you can tweak one or two variables, you can do this over and over and over either with the same group of people or with different groups of people or across groups of people, and then you're putting it in a simulation so it's relatively low risk in terms of people feeling comfortable. So I think it's helpful both as a teaching tool and as an educational research method.

Dr. Nathan Kuppermann (27:58):

As all physicians in the world have experienced, we face patients as they come as themselves, as they appear, and they come with their whole life experience and the feelings that they have. And if you're not trained, it's easy as a physician to take things personally when in fact patients are just being who they are. So I never received training for, and escalations are one thing, but what it sounds like, what appeared to be microaggressions, and whatnot. For me, it's critical that physicians don't personalize this. Our job is to take care of each patient the best way we know how, no matter how they are presenting to us. And this

sort of training seems invaluable, but it wasn't probably the initial focus of simulation training, but it's been, I don't want to say adapted because you have your own curriculum, but I think it's been put to great use, particularly at Children's with education.

Dr. Priti D. Bhansali (28:58):

And then I know that there's a pretty incredible simulation that is done as part of the advocacy training as well.

Dr. Nathan Kuppermann (29:05):

Yeah. Lanre, why don't you talk about that?

Dr. Lanre Omolayo Falusi (29:07):

Yeah. So in a sort of non-clinical simulation training we, in a couple of different ways, one, we partnered with an organization called Total Family Care Coalition, sort of like a parent support group. Their executive director, Ms. Gail Avent, who's amazing, she worked with us to develop a simulation, sort of a day in the life of a family who may have limited resources and has to make decisions around type of transportation, where they would live, where to get food. And we used real numbers and real situations and real neighborhoods to help the residents calculate what decisions families make. And we find that people will see how hard it is for family to stretch a limited income over all of those needs.

(29:56):

There's another simulation that we do related. To a partnership that we have with Capital Area Food Bank, a large food bank in the area, where we actually go to their site and do a simulation where a resident or, actually that's open to anyone in the hospital, so maybe a nutritionist, maybe a dentist, is a family and they have to figure out how to survive for the week with that family and with the money and resources that they have.

(30:27):

One thing that's been really interesting, because that is live in person in a group, is that as we sort of watch the group go through the week, people start with a little bit giggling. It's trying to figure out, do I have to go across the room to drop my child off at school? I forgot to drop my child off today. Let me figure that out. By the end, people are stressed. I think what we've been able to build there is at minimum the affective piece of living with limited income. And again, this is like a one-hour simulation. People go back to their normal lives after this, unlike many of our families. So it's clearly a simulation and not meant to be real life. But by the end, they're stressed. They had to stand in line at the Social Services office. And while they're there, they missed the time that the food bank was open. So it's now closed and they didn't get food for the day.

(31:21):

And really they have limitations in terms of literacy. They're given a form in a language that they can't understand. So we try to really simulate some of those barriers that families may experience. The really important part of simulation or an important part is a debrief afterwards. And we find that to be also a time that we can cement the learning. So this was not just a way for you to see what a family might experience in a day, not just meant to stress you out for this past hour, but now let's talk about how you'll bring what you've learned into the exam room, into your interactions with families so that we are, again, bridging the gap across clinician and patient and family.

Dr. Nathan Kuppermann (32:04):

In the modern era, you guys have ways to, besides the participant's sense of stress and the debrief, do you put monitors on residents and whatnot to assess heart rates and et cetera, et cetera? Prit, what...

Dr. Priti D. Bhansali (32:18):

There's a group of people at Children's led by Amy Wolfe, who's one of our critical care docs and a whole team of her collaborators that are looking at heart rate variability and other physiologic stressors as pertains to communication in these stressful encounters. So I think there's a lot of exciting work that's being done by her team. Yeah.

Dr. Nathan Kuppermann (32:40):

One of my lines of research is around the assessment of the babies with fever and how to decrease the number of spinal taps that we do. And I'm in the middle of writing a commentary piece and the reviewer is saying, "Well, if we don't do these spinal taps, well then residents won't be good at them?" And I was saying, "That's not really a good justification to do spinal taps because we don't practice on humans. We have simulation to practice on." And interestingly, I don't know if in the education space you do this, but do you ever do simulations using virtual reality, goggles, et cetera?

Dr. Priti D. Bhansali (33:16):

Most of my experience with simulation is actually as a participant. So I can 100% endorse it after doing the simulation that you were talking about. I was stressed. And I will say that these other verbal deescalation simulations and the microaggression simulation trainings were very authentic, I would say, in a way that's a little bit different than using virtual reality, which I have also had the opportunity to participate with the goggles and seeing what's going on in the room and turning to the side and all of a sudden there's an avatar of another healthcare provider there. And so that's really fun and adds to the authenticity, I think. But I think a lot of the other simulations that are maybe low fidelity work just as well.

Dr. Lanre Omolayo Falusi (34:05):

It is fun to use that technology. The nice thing about it also is that it's scalable, I imagine, so that you don't have to spend the hours setting up the room and all the mannequins or whatever, the stations, and rather a program can download that onto their devices, so that part is nice. But yes, I agree. Low tech works just as well, even though there are some benefits to doing the VR goggles sort of simulation.

Dr. Nathan Kuppermann (34:32):

So as we're slowly winding down, I have a few last questions that I'd like to ask both of you. First of all, I want to ask each of you, what do you see as the future over the next decade specifically around research and education? Where's the field going? Let me start with you, Lanre.

Dr. Lanre Omolayo Falusi (34:49):

I think first who is learning together is a question that we're asking now that I think will only continue to grow. We have a lot of interdisciplinary education right now. For example, at Children's with a partnership with George Washington University, we have graduate medical education tracks where people who are residents and fellows in pediatrics or OBGYN or internal medicine are learning together things like QI and patient safety and advocacy and policy.

(35:17):

The next step though is really being more interprofessional. So not just physicians or physicians in training, but also nurses and social workers and others who are part of our healthcare team learning

together. And I think that there are places where that's happening at Children's and elsewhere, but there's so much more that we can do with that.

(35:38):

Hard to talk about the future without mentioning artificial intelligence. I mean, AI seeps into everything now, so I'll just say that. I think that there are so much promise, but we also have to be very responsible, I think, with where we incorporate AI and not just where it's like a shiny new object, but that it really does add to the learning or to our assessment of the learning in a way that's reasonable.

(36:05):

I also have to talk about community-based medical education or health professions education. I think, again, that is growing, and that's where I think the future is also where we break down the walls of where people learn or who is teaching. That doesn't need to be the MD, PhD, MED. It can be and should be also the parent, the family, the community health worker, the community organization leader, the policy expert, the elected official. So there are lots of people who can be, and I think in the future will continue to be part of our learning ecosystem.

Dr. Nathan Kuppermann (36:44):

Prit, how about you?

Dr. Priti D. Bhansali (36:45):

I mean, she stole my answers, but yeah, I would support everything that you just said. Yeah.

Dr. Nathan Kuppermann (36:53):

So Prit, I'm not going to let you completely get away with that, because I'm going to ask a follow-on question, which is if you had the ability to design the ideal health professions education research program, infrastructure, mentorship, money, time, et cetera, what would that look like?

Dr. Priti D. Bhansali (37:14):

Oh, wow. This seems like I could go on for a very long time. So I would start with, I think there needs to be professional development training. A lot of people come to research or health professions education research a little bit later in their careers after all of this training that they've had and so I'd certainly want to make sure that there was professional development in health professions education research, and there are programs that do that. I certainly would want protected time then for those individuals to carry out some of these projects, to be able to get those grants, to be able to do the big project that they're hopefully going to be able to demonstrate one day patient outcomes, definitely funding for those endeavors, mentorship and support from people like yourself and other sponsors that are willing to highlight and elevate the health professions education research that is being done.

Dr. Nathan Kuppermann (38:12):

The last question I have is for physicians, health professionals earlier in their career, I mean as early in their career, what do you say to encourage folks who might be interested in pursuing a career in health professions education research? What would be your words of wisdom?

Dr. Lanre Omolayo Falusi (38:31):

I think the first thing would be to find a mentor. So to your point, Prit, it may seem like you can walk in and figure it out, but there's so many layers, so many opportunities that are hard to figure out without a guide. So for me, it was finding the people who were doing the things that I thought I wanted to do in the future. So finding those mentors within your institution or outside of your institution if needed.

(38:59):

The second thing is, and this may be counter to some advice that people get, but in the beginning at least say more yeses than nos. I think we're all more and more being primed to set your boundaries and learn how to say no gracefully. But I think in the beginning it's wise to say yes, even if you don't have all of the information, but if you have a good mentor, a trusted person who is taking you under their wing or pointing you toward opportunities, it usually does not hurt to at least try it out before maybe a few years down the line, then kind of figuring out where your niche is and peeling back where you need to.

Dr. Nathan Kuppermann (39:39):

Prit, let me give you a crack at that too, your thoughts, words of wisdom to encourage people to pursue this line of work in medicine.

Dr. Priti D. Bhansali (39:47):

It's so gratifying. You'll never regret it. And I do think that saying yes early on makes sense. You never know what you'll be into unless you try it. And so I would encourage people to yes, have a mentor. It's very exciting. You'll find your people. Educators generally have hearts of gold and that passion will sort of get you through the rough spots.

Dr. Nathan Kuppermann (40:13):

So before we close, what you guys are making me think for me as the chair of pediatrics and the chief academic officer, I need to bring more resources to the table to help you guys build out these programs. And I'm kind of looking to our listeners to help me out a little bit in these complicated financial times. But obviously what you guys do is critically important all joking aside to really to train the next generation of educators on how is the best way to educate, the best way to communicate that ultimately impacts the way we care for the children that we serve. So with that, Dr. Prit Bhansali, Dr. Lanre Falusi, really appreciate you joining me on this episode of The Lead in Peds.

Dr. Priti D. Bhansali (41:01):

Thanks. It's been fun.

Dr. Lanre Omolayo Falusi (41:02):

Thank you so much. It was so fun.

Dr. Nathan Kuppermann (41:03):

Today we talked about health professions education research, what it is, why it matters, and how it helps us prepare healthcare professionals to deliver better care for children and families. It's clear that this work is about much more than generating a curriculum. It's about asking the right questions, studying teaching and learning with rigor, partnering with communities, listening to patients and families, and creating training environments where clinicians can practice the skills that matter most. And this requires research in education. I want to thank Dr. Falusi and Dr. Bhansali for joining us and for the work they do to advance health professions education research and patient care at [Children's National](#) and beyond. And thank you for listening to The Lead in Peds from Children's National. [Be sure to subscribe wherever you get your podcasts](#) so you don't miss future conversations with leaders who are advancing the future of pediatric medicine.