

INTERCOM

SOCIETY FOR ACADEMIC CONTINUING MEDICAL EDUCATION

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CME's Changing Image

Contributed Essay

ACADEMIC CME: An Endangered Species?

Albert J. Finestone, M.D., M.Sc.

Even though this CME Office has done well over many years and continues to perform well in all aspects of its operations, including financial, I am prompted to submit these comments in response to two related recent papers. The first paper by Professor Uwe Reinhardt pointed out that "*Congress asked academic medicine to help cover one of Congress' glaring moral shortcomings: its failure to ensure equitable access to timely health care to millions of uninsured Americans.*"⁽¹⁾ I am amazed by the lack of outrage to this fact by both the medical profession and the general public.

The second paper which reviewed U.S. medical school finances pointed out that *34.5% of revenues of all accredited U.S. medical schools came from practice plans.*⁽²⁾ Practice plans of academic health centers provide much of this unreimbursed care with considerable negative financial results. In these difficult financial times for many academic health centers, particularly those in urban locations, funding for CME by medical schools is of low priority. Even though Congress recently passed the HHS budget for fiscal year 2001 and signed into law by President Clinton on December 21, 2000, may help address some of the financial problems, I believe it will not provide a quick solution.

Looking back over close to thirty years in academic CME, I am motivated to comment concerning the "state" of our CME enterprise. First, the good news, CME is now recognized as an integral part of the academic mission of medical schools and accordingly, is placed in a better position to respond to educational and medical (even "moral") shortcomings.

Now for the developments which in my view are negative and inhibit CME's ability to respond: As a practicing internist, I am deluged by all varieties of CME programs, via fax and surface mail by both academic and non-academic CME organizations. These encompass traditional lecture programs, dinner meetings, travel programs at vacation sites, Internet, on-line programs and enduring materials. Many lack a clear educational focus; many promote recreation over education, thereby damaging the image of CME in both the public's and the professional's eye.

How has this development come about? When I started in CME, our professional organization was the Society of Medical College Directors of CME, now the Society of Academic CME. Our early deliberations primarily concerned adult education concepts since most of the initial members were physicians, not trained educators.

(continued, page 4)

**Good News for
Researchers, Providers
and Readers!**

**JCEHP
TO BE INCLUDED IN
INDEX MEDICUS AND
MEDLINE!**

In February 2001, the National Library of Medicine (NLM) recommended The Journal of Continuing Education in the Health Professions (JCEHP) to be indexed and included in Index Medicus and MEDLINE. NLM will begin indexing with the calendar year 2000.

Congratulations to the current editor, Paul Mazmanian, and immediate past editor, Bob Fox, and to all who wrote and submitted articles over the Journal's 21 year history, to those who served as consulting editors, members of the Administrative Board, To BC Decker Inc, and the members of the three-owner organization who promote and support the Journal!

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President' Column

The Complexion of our Society

There are three broad, but related, sections to this article. First, how do we think about our Society as a forum for the expression of our ideas? Second, in a more formal sense, how do the Bylaws of our Society represent us to the "outside" world? Third, how does what we do when we are together encourage these expressions.

What we are as an organization is the sum of our actions and interactions. Are you represented?

(1) One of the hallmarks of an academic environment is the sense of freedom that exists for open discussion. Whether the thoughts are new, the issues unique or the actions controversial, there is the expectation that expressing one's views and openly contrasting ideas are healthy, constructive practices. While it is not always possible to reach full consensus, engaging in the process has its own benefits.

One role of an academic society like SACME, is to support a forum for such dialogue. We need to be sure we continue to provide arenas for airing differences of opinion. Open discussion at our meetings, ongoing discourse on the listserv, editorials in newsletters all provide the give and take that encourages points of view and helps lead to better-informed decisions.

But, we are just one piece of a broad, overlapping network of organizations involved with the education of healthcare professionals. Not only do other organizations participate in similar practices, but in a larger sense, this also happens across organizations. Do your Society leaders participate in these interactions? You bet they do. Most issues are reported back to membership in some fashion. Those of a more sensitive nature are treated with appropriate confidentiality.

When was the last time you communicated your concerns to a Society Board member?

(2) *Bylaws Issues*

At our Spring meeting in Lexington, on Wednesday afternoon at 5:30, members can participate in a discussion around planned Society Bylaws changes. The major issue remaining is



the restructuring of Membership Categories. Additional minor changes include: restating the Society's Mission and Goals; and, possible elimination of the Secretary position on the Board. The draft of the Bylaws on the Society Website (www.sacme.org) reflects these changes. Please take the time to look them over before the Spring meeting.

With member input and Bylaws Committee discussion, the following has been proposed. This will provide an opportunity for membership to those CME professionals not based at academic medical centers, but yet still involved in academic CME pursuits.

Categories of Membership would include:

- **Voting:** All members, other than honorary or emeritus, once approved by the Board, would be considered voting members. This combines voting, associate, continuing and corresponding into a single category. (Dues paying)
- **Honorary** (No Dues)
- **Emeritus** (No Dues)

Membership Applications would be accepted from:

- Organizations *accredited* by the LCME

All applications are to be signed by the medical school dean, and processed through normal Society Membership Committee channels.

- *Others involved in academic CME initiatives, at special invitation from the Society Board*

Applications would be handled through normal channels and sent to the Board for approval. These 'Board approved' memberships would be reviewed regularly. In all other respects Board approved members would have full voting and other member rights and privileges.

(3) **Spring meeting April 3-7, 2001, Lexington, Kentucky**

You should all have received the Spring Society program materials and by now be planning your personal networking sessions. The Spring meeting is one of only two regularly scheduled annual gatherings of the Society. Check out the full program on the Society Website at: www.sacme.org.

Much of the real effort of our organization occurs at the committee level. And much of the personal and professional benefit to Society membership derives from this committee interaction. The committees will meet throughout the morning on Wednesday, 4/4. I encourage each of you to make the time to meet with your colleagues, voice your views or concerns and help guide the efforts of your professional organization.

By now, you have heard or read about the ACGME general competencies. The potential use of these competencies by CME will be the primary focus for the Wednesday afternoon opening session. This session and the ensuing dialogue will mirror the national debate occurring within many professional societies around measuring physician performance. Plan to be a part of it!

The SACME Reception will be Wednesday evening, 4/4 at 6:30. This is always a great time to renew acquaintances and meet new Society members. Don't forget the Society Business meeting/luncheon on Friday, 4/6, at noon. The reports given and the discussion with the membership help us all to stay up to date with the wide variety of activities that involve your Society.

See you in Lexington!

Paul J Lambiasi
President 2000-2001

A Needed Partnership between Peer Review Organizations and Continuing Medical Education

By

Jan Z. Temple, Ph.D.

**Director of Professional Development, Continuing Medical Education
Medical University of South Carolina**

Organizations and clients with common causes can be strengthened by collaborative partnerships. CME and Peer Review Organization's (PRO) use education and research to improve health outcomes. The two groups also recognize physician involvement as critical to the quality improvement process. CME emphasizes enhancement of physician knowledge and practice patterns as well as the translation of research into clinical application while PRO's focus on system and individual change to improve health care quality for Medicare beneficiaries. Physicians provide the commonality for both organizations to begin collaboration discussions and address needed change.

Both CME and PRO's face constant change and increased accountability.

Within the next two years PRO's will be required to document improvement in quality indicators for six clinical disease areas. As change agent-facilitators, PRO's do not exercise dominion over health care centers, hospitals or physicians, yet they are accountable for documentation and enhancement of quality improvement. System and individual physician performance improvements are primary areas of needed emphasis. Physician adherence to recommended national guidelines, as well as the ability to document improvement in health outcomes, are also areas of needed improvement.

CME must address new accreditation standards which require documenting efforts of enhancing physician practice patterns and health outcomes. This effort will establish baseline need assessments, and involve quality improvement initiatives and educational interventions that result in physician behavior change. Follow-up studies conducted to determine if physician practice patterns have been enhanced is a task not frequently performed by most CME units due to limited resources and research skills. CME faces the challenge of documenting improvements in physician performance and the overall impact of those improvements on health outcomes.

PRO's can provide clinical research studies that can serve as a needs assessment tools for CME to use in program design. The effects of educational interventions can then be analyzed through collaborative follow up studies to determine if physician practice patterns have changed. CME has often established communication with physicians and hospital providers which may be of benefit to the PROs. CME also has expertise in adult learning theory that is critical to success.

Strategically, both organizations should prosper if a collaboration effort is associated with a win-win approach. Steve Jencks, MD, MPH, Director of the Quality Improvement Group in the Office of Clinical Standards and Quality at HCFA, advocated partnerships in his presentation at the AHQA Technical conference in Orlando in February

2000. He supports alignment with organizations that have similar goals. HCFA is establishing an advisory committee to identify and address partnership needs at the national level.

Recently, SACME leadership participated in a "Changing Physicians Behavior" workshop for PRO medical directors. It served as the first step in what will hopefully become an ongoing working relationship between both organizations. A draft document and a plan of action is under development for presentation to both organizations for endorsement later this year.

Partnerships and collaborations are critical to CME efforts to enhance physician practice patterns and transition research into clinical application. Data will soon be released by HCFA that will identify state performance in six clinical topic areas. They include heart failure, diabetes, pneumonia, acute myocardial infarction, stroke and breast cancer. This data will provide valuable information to CME through focused attention on select disease areas where enhancing physician performance will be measured. Such data provides participants with an opportunity to network, maximize resources, and focus attention on identified health needs.

The logical approach for CME and PRO's is to advocate partnerships at the state and local level. The challenge is before us... "Can we put differences aside and join forces with the PRO community to enhance health outcomes for all of society?"

THE RDRD TURNS 21

A LOOK BACK...

The Research and Development Resource Base in Continuing Medical Education (RDRB/CME) at the University of Toronto is a literature database for educators and health professionals to assist them in their study of program evaluation, physician performance, change, and health care outcomes. The scope and size of this database reflects the volume of research in continuing medical education and related fields.

Beginning over twenty years ago as a hard copy review of about 200 papers in CME called 'The Impact of CME: an annotated bibliography', the RDRB owes its life and vigour today to a number of individuals and groups.

To the late Eva Feldman of McMaster who suggested the need for such a database, through a succession of librarians from Ann McKibbin in the 1980's to Anne Taylor-Vaisey in the 1990's, the database has been well supported by talented and helpful individuals. Many recall, in particular, Anne's support, a significant factor in the growth of CME research. As well, a special thanks to Anita Lambert-Lanning for maintaining the RDRB and bringing it into 2001. In addition, support has come in more tangible (i.e. dollars) forms from the Society for Academic CME, the Alliance for CME, the Royal College of Physicians and Surgeons of Canada, the AMA, and other sources, especially the University of Toronto Academic Development Fund in CE.

THE RDRB TODAY

Now shepherded by Laure Perrier, the University of Toronto's Webmaster and information scientist, the RDRB has grown considerable. Close to 9000 references are housed on the database including journal articles, and conference abstracts along with other materials, making this a valuable tool in facilitating research and development in CME and continuing professional development.

Many items contribute to the database through the addition of conference abstracts including the Society for Academic CME annual conference, as well as literature searches. Literature searches are conducted on widely diverse topics relating to continuing education in the health professions, ranging from basic continuing education competencies to specific learning tools and/or clinical conditions. These literature searches draw from various sources including Medline®, ERIC (educational resources information centre), CINAHL® (Cumulative Index to Nursing & Allied Health Literature), HEALTHSTAR, and EMBASE.

ACCESSING THE WEALTH OF INFORMATION ON THE RDRB

Users have access to the RDRB in several ways. It is available through the University of Toronto CME website at <http://www.cme.utoronto.ca/RDRB/default.htm>. It is possible to search the RDRB online by using the **rdrbweb link**. This link allows users to conduct their own searches of the RDRB and receive a list of citations. As well, searches are done using the RDRB with the submission of a request identifying a topic of interest. RDRB research request forms and information on submitting these can be found on the website. Alternatively, the website offers other access points into the CME literature. The literature can be sampled by clicking the bibliographies link that provides retrieval of notable articles and books in topical areas of continuing education. This area of the website also provides links to home pages of journals such as *Academic Medicine*, *CMAJ*, *JAMA*, *Journal of Continuing Education in the Health Professions*, and *Medical Education* through the self directed searching section (see links entitled major medical journals, and medical education journals).

Now officially coming of age, the RDRB exists as a superb resource for all CE/CPD providers – in creating research proposals, when planning innovative CE strategies, in thinking through a theoretical base for educational activities, in presenting to colleagues. Come visit us.

Dave Davis, MD
Laure Perrier, MLIS

Summer Research Institute June 24-29, 2001

Bring your research project and plan to attend the Summer Research Institute at the University of Calgary, Calgary, Alberta, Canada. The format will include morning didactic sessions on research skills followed by afternoon sessions for individualized work with mentors who are experts in CME research. Topics include:

Framing the Research Question
Literature Searching Techniques and Critical Appraisal of Literature
Quantitative Research Skills
Qualitative Research Skills
Dissemination of Results: Presentations, Posters and Publications

For more information, contact Jocelyn Lockyer, Nancy Davis, Barbara Barnes or Jack Kues.

(Academic CME, continued from page 1)

The Society's emphasis on education contributed, I am proud to note, to Temple's CME office being one of the first to hire a trained educator as part of its professional staff. It is now directed by an adult educator. Many institutions have followed suit; however, not enough—judging by the promotional advertising that crosses my desk.

Another CME organization, The Alliance for CME, with over 2,300 members represents corporations, hospitals, advertising, medical agencies, publishing companies and even pharmaceutical companies, as well as medical schools and individual members. Members of all groups are expected to adhere to the same standards established by the Accreditation Council for CME to maintain their ability to provide Category 1 CME credits. In my opinion, they do not have a level playing field.

How can medical schools CME compete for financial support with these organizations who have direct and indirect links to major funding or who are organizations experienced in commercial funding solicitation? Although some academic CME offices have joined the chase for commercial company dollars, they may have "sold their soul to the company store." Even the most prestigious and well-endowed medical schools are not exempt from outside support and must depend on faculty practice plans for varying amounts of their budget. In many instances, these plans are in deficit due to decreased reimbursement for uninsured patient care.

How can we address some of these problems? I propose that academic CME units should be able to monitor their own activities, much after the model in Pennsylvania (Pitt, Temple, Penn State and Jefferson), where this consortium is accredited by ACCME. This consortium, received full six-year accreditation at its most recent review. Similar groups could easily be developed across the country, thereby allowing the ACCME to focus on Intercom, Volume 14, Number 1
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the large numbers of commercial providers and other organizations that may need closer supervision.

Mark Schaffer, in his paper "*Commercial support and the quandary of continuing medical education*" correctly observes the issues of "control," logistical assistance, curriculum, how the speakers are selected and paid by an unrestricted educational grant, dance around the real issue of commercial support as we try to adhere to the published "standards."⁽³⁾

Such suggestions will not solve the problem or change the system, i.e., appeal to physicians to turn down "freebies," dinners, etc. Some will and some will not just say no to providers, like Nancy Reagan's "just say no to drugs," will not happen.

Wentz and Paulos have recently observed that current CME has been heavily dependent on funding from the pharmaceutical industry.⁽⁴⁾ They also ask "can other funding solutions be explored?" I offer this solution: Have a foundation (new or existing), solicit commercial support (pharmaceutical companies, medical equipment manufacturers, etc.) for academic CME, with distribution by a mutually acceptable formula developed by all participating parties. I believe this solution has precedents. I was Chair of the Society's first research committee, but without funds, nothing happened. However, I believe Harold Paul obtained Foundation support and important activities followed.

This funding solution would free academic CME of the current rules governing commercial support, which allow subterfuge. For example, a medical school currently can present a program supported by an "unrestricted" educational grant from a pharmaceutical company. However, in most circumstances the company who makes a product to treat diabetes, hypertension G.I. disorders and rheumatologic disorders, will support a program only relating to one of these problems. Any physician attending these programs is reminded about the company and the product. The company's message is reinforced. Academic CME

with the most contacts with these commercial organizations or with faculty members with national reputations in these specific medical conditions have a "leg up" on tapping commercial support. But really, is this Academic CME's mission? I urge you. Academic CME should cry "free at last!" from the onus of soliciting commercial funds and concentrate on its primary mission of education with the aim of changing physician behavior to improve the quality of medical care when needed.

The following conclusions from the Accreditation and Credit Task Force report from the Society for Academic CME seem relevant to this paper.

Conclusion to questions #3-4: In terms of resources to support teaching and learning, accredited CME organizations are not in the same category as medical schools.

Conclusion to questions #5-6: Most respondents agree that the ACCME is extraordinarily influenced by the AMA and that they have a conflict of interest.

Conclusion to question #8: The large majority feels that the ACCME does not represent the best interests of medical schools.

The paper by John Parsoosingh on credentialing physicians is clearly a step in the right direction. I believe we now may be stuck with the category 1 concept, but I still firmly believe that it is time for knowledge testing, practice application testing and a periodic physical examination for all physicians. With specialty boards, hospitals and State licensing boards, we can move toward this goal rather quickly without any new bureaucracy.⁽⁶⁾

Further moves in this direction are occurring. The American Board of Internal Medicine has announced a new program of Continuing Professional Development (CPD). A group of distinguished colleagues in CME has recently published a vision of what CME should become in our changing health care environment⁽⁷⁾ This is a dramatic step forward.

It may be best for academic CME to be accredited by the AAMC since this is clearly a medical school activity.

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Recommended Reading

Subject: Standardized patients as indicators of quality of care.

There is an interesting article in December's *JAMA* (Peabody, et al, p. 1715, vol 283, no 13, 4/5/00) that compares standardized patients, clinical vignettes and abstracted chartprofessionals. It is also a useful tool for those who are planning a career path.

Readers may want to take another look at the *New England Journal* (Dec 23, 1999, vol 341, pp 1980-5) on physician's perception of the appropriateness of scope of practice for primary care physicians. 24% of PCP's and 38% of specialists felt that the scope of services provided in primary care is too broad. Internists, pediatricians, and those who are highly capitated, gatekeepers and/or in small groups are like to express discomfort with the breadth of their responsibilities. Although the date is old (1996-1997), it raises interesting questions for CME. Do these physicians perceive this as a gap that can be narrowed by learning more or do they think that the responsibilities are beyond their scope of training and professional practice and therefore non-remediable? Are there personality, motivational, or learning characteristics that differentiate those who feel comfortable providing a wide variety of services from those that are concerned? This will continue to be an interesting debate as physicians have decreasing levels of control over the types of patients they see.

Members are encouraged to submit synopses of articles that would benefit the membership.

The ACCME Report Volume 9, No. 2 - Summer 2000

The Official Newsletter of the Accreditation Council for Continuing Medical Education Summer 2000 Issue describes new guidelines for determining compliance with the **ACCME's Standards for Commercial Support**. Providers are expected to demonstrate compliance after **October 1, 2001**.

The guidelines underline the responsibilities of the accredited provider to assure the scientific integrity and freedom from bias of the subject matter. *"After each activity, the ACCME accredited provider must ascertain directly from the learners and faculty if the learners or faculty perceived that the activity was commercially biased, and if commercial bias is perceived, the accredited provider must document the steps that will be taken to detect and prevent the presence of such bias in the future."*

SOCIETY WEB PAGE

If you have not done so already, check out the Society's web page at <http://www.sacme.org>.

Look for future issues of INTERCOM on the Society's web page.

(Academic CME, continued from page 4)

Reinhardt, Uwe E. Academic Medicine's Financial Accountability and Responsibility. *JAMA* 2000;284. 1136-1138.

Krakower JY, Coble TY, Williams DJ, James RF. Review of U.S. Medical Schools Finances, 1998-1999. *JAMA* 2000;284. 1127-1129.

Schaffer MH, Commercial Support and the Quandary of Continuing Medical Education. *Journal of Continuing Education in the Health Professions* 2000;20. 120-126.

Wentz DK and Paulos G. Is now the time of Continuing Medical Education to Become Continuing Professional Development. *Journal of Continuing Education in the Health Professions* 2000;20. 151-187.

Parboosingh J. Credentialing Physicians: Challenges for Continuing Medical Education. *Journal of Continuing Education in the Health Professions* 2000;20. 188-190.

Finestone AJ. CME & Clinical Competence: Is It Time for Mandatory Relicensure and Recertification. *Journal of Continuing Education in the Health Professions* 1988;8. 67-70.

Bennett NL, Davis DA, Eastling Jr. WE, Freedman P. et.al. *Academic Medicine* 2000;75: 1167-1172.

Albert J. Finestone, M.D., M.Sc. is Professor of Medicine, and Associate Dean CME, Emeritus Medical Consultant Institute on Aging, Temple University School of Medicine. He is Co-Director, Geriatric Education Center of Pennsylvania (Consortium between University of Pittsburgh, Penn State University and Temple University.)

From Reactive to Proactive – A CME Service Perspective

By Melinda Steele, M.Ed.,

**Director, Continuing Medical Education
Texas Tech University Health Sciences
Center; Lubbock, Texas**

A number of years ago, when the Office of CME was perceived merely as a rubber stamp for credit, a clinical department chair made a comment to me and then Director Margaret Teague, that for him CME was simply a “Black Hole” in which everything went in and nothing ever came out. That comment became the impetus for much pause and reflection for CME at Texas Tech University Health Sciences Center. What he was saying to us was that CME was in a reactive rather than a proactive posture. When an activity was presented with a request for credit, that is all that the department received, credit. Money was paid, credit was “stamped”. As cold as that sounds, it was an accurate depiction of the reality at the time.

Concurrent with this event were the radical changes that took place with regard to commercial support of CME activities, a tightening of the enforcement of CME accreditation rules, an upheaval in the mix of funding for continuing education in the State of Texas and the entry of managed care into the equation of the practice of medicine. It is no surprise, then, that physicians were in a negative mode of thinking and were critical of anything that was not deriving a direct benefit. In light of these events, the administrative staff in the Office of CME retreated and began the process of moving CME at Texas Tech from a reactive, non-facilitative mode to a proactive, service orientation. The process for achieving this goal did not happen overnight and, in fact, is still an on-going process.

The first step we took was for the Director and Associate Director to meet with every clinical department chair to seek input as to what their expectations were of the Office of CME. They were asked what services they would like to receive from the Office of CME and what problems or negative perceptions they might have, as well as possible solutions that could change those nega-

tive perceptions. The outcome of our discussions was that the department chairs wanted a more active participation from CME staff in the planning and execution of CME activities. Rather than processing paper, they wanted us to be more active in the planning process, step up communication with speakers and commercial supporters, and become a visible presence at all CME activities. A very positive measure we took was to help each department formulate and distribute what has become an annual needs survey of faculty and community physicians. The Office of CME compiled the data and then worked with the departments to implement activities that met the perceived needs of the physicians.

Beyond meeting with the department chairs, the CME Committee was also restructured. With four campuses at significant distance from each other, logistics of committee meetings were difficult. The restructuring of the committee followed a realignment of the Office of CME in the reporting structure of the School of Medicine. The Office of CME was moved from an independent reporting line to the Dean to be aligned under the Associate Dean for Educational Programs, who also was responsible for GME and UGME. The CME committee was modeled after an existing structure for GME and UGME. Each of the four campuses has a local CME committee made up of key program directors and department faculty representatives. These committees review issues impacting CME in their community and provide input and feedback to the CME manager at that campus. They also funnel ideas and issues of concern to the CME Executive Committee. Local campus CME committees meet every other month. The CME Executive Committee is comprised of the Assistant Deans for Medical Education and the CME managers from each campus, the Director of CME, and the Associate Dean for Educational Programs. The CME Executive Committee sets policies and reviews the local campus issues for rulings

or interpretation. CME Executive Committee meetings occur quarterly. This committee structure has worked well and has empowered the faculty at each campus and department to have an active role in the CME process. It has also relieved the staff from the sole burden of difficult or unpopular decisions, placing responsibility with the local campus committee and CME Executive committee.

Within the traditional arena of CME, the Office of CME reorganized services to provide a comprehensive meeting management option. This option has been so successful that only one or two events are still managed by the sponsoring departments. Within the context of offering comprehensive meeting management, the faculty and program directors play an active role in identifying the speakers and setting the curriculum, and remain active in the decision making process regarding logistics of the meeting. The Office of CME has removed the burden of the detailed planning process that goes on with every event from the sponsoring department, freeing departmental staff who previously performed these functions to do other tasks. The CME staff has become so proficient with the meeting management that our reputation is well known within the School of Medicine. Letters of commendation regarding CME staff frequently follow CME events.

With our success in dispelling the image of the “Black Hole” through improving the services we provide to our departments and joint sponsors, the Office of CME now enjoys a positive reputation. Recently, a new round of discussions with clinical department chairs, the Director for CME and Associate Dean for Educational Programs yielded positive impressions of the Office of CME and suggestions for new directions to better serve the needs of the faculty and community physicians. With the positive reputation in the traditional CME roles, we are being asked to expand our roles and move CME at Texas Tech to the next level. The new initiatives and projects we have underway will
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enhance our function in the School of Medicine and bring an increased credibility level to the services and products offered by the Office of CME. Some of the initiatives being pursued include:

- Faculty Development series on Effective Medical Teaching
- Development of Internet CME activities
- Development of Certificate Programs; a series of CME modules on related topics leading to a certificate in that area
- Production of an "Update Series" of programs for the Primary Care Physician, emphasizing a different group of subspecialty topics in each program
- Pursuit of external partnerships for new initiatives, funding and additional joint projects

The clinical department chair responsible for the "Black Hole" analogy several years ago is now one of the strongest advocates for the Office of CME at Texas Tech, providing the best evidence of our successful turn around from reactive to proactive in the provision of service to the School of Medicine. Making the faculty an integral part of the process ultimately created successful partnerships that benefited not only the Office of CME, but also the entire School of Medicine.

Melinda has been a CME professional since 1992. She previously served as Manager, Associate Director, and Interim Director of CME at Texas Tech. Her Masters degree is in the area of Instructional Technology and she has over 20 years of experience in the field of education.

Questions of the month:

directed to Greg Paulos, Associate Director , AMA Office of Continuing Physician Development

With the publishing of Version 3.0 PRA information Booklet for CME Providers, has the AMA changed its expectation relating to providers recording AMA Category 1 credit?

Greg Not significantly. Version 3.0 was issued in a new format, with a rearrangement of information. You will find similar information in earlier versions of the booklet. Over time, the AMA has consistently expected accredited sponsors to maintain records of category 1 credit for physicians requiring documentation or verification.

With regard to a CME provider maintaining records of category 1 credit for physicians, what are some reasonable methods one might use?

Greg The AMA does not specify the method by which credit is recorded. That decision is left to the individual provider; given the breadth, scope and variety of educational offerings and learning activities, it is best determined by each provider activity by activity. Physicians, as well, have a responsibility to contribute to the recording of their hours at each activity designated category 1—The AMA expects individual physicians to claim only the hours actually spent participating in the activity or studying the materials within the maximum number of hours designated.

Examples of methods a provider *might use, but is not limited to*, include: a log of the activity (one log per individual) or simply, a sign-in list of all attendees' names with opportunity, for each to initial in and reflect his/her actual attendance at program sections/presentations. Depending upon what best suits the format of the educational offering, one also might consider an exam or a proctored review or an evaluation, an essay or a written reaction or a multitude of other educational venues.

For any of the methodologies used, the responsibility for helping physicians keep their credit hours is with the CME provider. Providers can:

- establish a system that can reflect actual hours claimed by the physician;
- ensure that instructions are clear and the system is available to the attendees at the activity;
- collect and maintain the records for the appropriate period expected, and provide documentation upon request.

Version 3.0 is available on line, www.ama-assn.org/cme or by phone, 312-464-4669.

Further discussion will follow at the SACME Spring Meeting. So-

Editorial Note: This memorandum was directed to the Academic leadership at Medical Schools. For those Offices/Units of Continuing Medical Education at Medical Schools who may have not had opportunity to review it electronically or from their academic unit, the text is provided along with the accompanying memorandum, below.

AAMC MEMORANDUM #00-32

July 31, 2000

TO: Council of Deans
Council of Academic Societies
Council of Teaching Hospitals and Health Systems
Organization of Student Representatives
Organization of Resident Representatives

FROM: Jordan J. Cohen, M.D., President

SUBJECT: Lifelong Professional Development and Maintenance of Competence

The attached statement entitled, "Lifelong Professional Development and Maintenance of Competence," was approved by the AAMC Executive Council at its June 16 meeting. The statement was developed in response to an initiative undertaken jointly by the American Board of Medical Specialties (ABMS) and the Council of Medical Specialty Societies (CMSS). The purpose of the joint initiative is to develop a mechanism by which the profession can assure the public that doctors are remaining competent over the course of their professional careers.

For a number of months, a Joint ABMS/CMSS Planning Committee has been working to develop recommendations on policies and procedures governing lifelong learning, practice assessment, and oversight activities, for presentation to the governing bodies of the two parent organizations. The AAMC has been an observer and, on occasion, an active participant in the discussions that have been occurring. However, the AAMC has not had in place a formal position on any of the relevant issues.

The attached statement was developed by the Council of Academic Societies Administrative Board, working with AAMC staff of the Division of Medical Education. The statement establishes AAMC positions on several of the issues now under discussion, which are generally supportive of the Joint Planning Committee's Recommendations.

Please note that the third paragraph of the statement outlines a new vision for continuing medical education (CME). This vision was adopted by an Advisory Committee on CME that was established to assist the staff of DME in developing an agenda for addressing a variety of CME-related issues. The AAMC, having established a CME Section within the AAMC Group on Educational Affairs, is well positioned to work on issues related to the implementation of the new vision.

See following:

**Association of American Medical Colleges Statement
on Lifelong Professional Development
And Maintenance of Competence**

The core mission of the Association of American Medical Colleges (AAMC) is to improve the quality of undergraduate, graduate, and continuing medical education. The ultimate purpose of the AAMC's mission is to ensure, to the greatest degree possible, that physicians who have completed the formal, structured stages of their medical education (undergraduate and graduate medical education programs) are competent to enter clinical practice, that they possess the attributes needed to be lifelong learners, and that they remain competent throughout their professional careers.

Continuing medical education (CME) is the predominant mechanism by which practicing physicians maintain their clinical competence. In recent years, the results of a number of studies have shown that traditional CME activities have limited effectiveness for improving physicians' practice behaviors. It is disconcerting to note, therefore, that the organizations responsible for developing the conceptual framework that governs the design and conduct of CME activities have not changed their policies and procedures in response to those research findings. This is particularly troubling, since the results of other studies have shown that the quality of care provided by physicians often fails to meet accepted norms of practice. Given this situation, the AAMC

believes that changes are needed in CME, which will result in the development of CME activities that will be effective in improving physicians' practice behaviors.

To achieve this goal, there first must be a new vision for CME - one that is based on an understanding of the kinds of educational activities that are most likely to assist physicians in their efforts to maintain their clinical competence. Recent evidence suggests that to be effective, CME should be highly self-directed with content, learning methods, and learning resources selected specifically for the purpose of maintaining or improving the knowledge, skills, and attitudes which physicians need on a regular basis in their practices. Individual CME activities should incorporate interactive learning formats, and include practice enabling and reinforcing strategies. To the degree possible, the learning experiences should be accessible within physicians' practice or work settings. In order for CME to be effective, physicians must recognize the knowledge, skills, and attitudes they need to maintain competence in their specialty of practice, and participate in CME activities designed specifically for that purpose.

The AAMC believes that specialty societies and specialty boards are best able to assist physicians in their efforts to maintain their clinical competence. To this end, the societies and boards should set forth on a regular basis the attributes that are needed to practice medicine on a specialty-specific basis, and should identify for physicians the valid kinds of CME activities that will allow them to maintain or acquire those attributes. The societies and boards also must develop new assessment methods that will allow them to determine whether or not individual physicians have developed and maintain the attributes needed for practice. While some specialty boards are in the process of actually implementing new assessment methodologies to achieve this purpose, the majority of boards are not.

The AAMC believes also that it is imperative that the profession establishes a system for assuring the public that individual physicians are maintaining their clinical competence. Neither performance on examinations that primarily test knowledge recall, nor participation in traditional CME activities, is an adequate way of assessing the clinical competence of physicians. Thus, these traditional methods should no longer be used as the sole basis for representing to the public that physicians are remaining clinically competent. One method by which this could be achieved would be to establish a body composed primarily, but not exclusively, of members of the profession, which would monitor and validate the policies and procedures used by the societies and boards to assess the clinical competence of physicians. By carrying out this function, the body would be in a position to assure the public that the methods being used by specialty societies and boards to indicate that physicians are maintaining their clinical competence are meaningful and appropriate.

The Association recognizes the magnitude of the challenge that this new vision of CME presents to the profession, and stands ready to assist specialty societies and boards in this effort. The AAMC can play an important role by promoting research on the effectiveness of various kinds of CME activities, and by providing opportunities for the exchange of information and ideas on how best to achieve the changes needed so that CME supports physicians' effort to maintain their clinical competence.

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MARION C. ANDERSON, MD

(As remembered by his former colleagues in the Office of Continuing Medical Education)

Dr. Marion C. Anderson, 74, of Charleston, a retired dean and former chairman of the Department of Surgery at the Medical University of South Carolina died Friday, February 2, 2001. Dr. Anderson was born in Concordia, Kansas. At MUSC he held the positions of Executive Associate Dean in the College of Medicine and Associate Dean for Continuing Medical Education and Graduate Medical Education. He served as president of the Medical College of Ohio in Toledo and was a member of the faculty at Northwestern University Medical School in Chicago. He was a member of the American Surgical Association.

He was known as a great teacher of surgery and physicians in Charleston described him as a tradition at MUSC. Beyond his reputation as the great surgeon, employees in Continuing Medical Education (CME) knew and respected him as their Department Dean and mentor.

Dr. Anderson took the position of Associate Dean for Continuing Medical Education when the office consisted of one person and offered limited services. Dr. Anderson met with Dr. Layton McCurdy in his first month as Dean of the College of Medicine and asked for his support of continuing medical education. Over the next decade Dr. Anderson continually raised the issue of the importance of continuing medical education and its relation to life long learning. As a result, continuing medical education and lifelong learning are recognized as important parts of the continuum of physician education by the College of Medicine and the university administration. Continuing medical education is now involved in many aspects of undergraduate and graduate medical education within the College of Medicine. As a result of Dr. Anderson's leadership, the Office of CME has grown in all areas from personnel to the amount and types of activities offered. His vision for continuing medical education went far beyond the traditional "live body" lecture. Ideas for web based courses and self-directed learning were presented by Dr. Anderson many years ago.

IN MEMORIAM

Dr. Anderson's involvement in national organizations such as AAMC and **SACME (Society for Academic Continuing Medical Education)** has allowed MUSC to be involved in national projects and research. **Dr. Anderson served as Secretary of SACME for four years.**

"I miss Dr. Anderson now but I am sure that there will be many instances in the future when I will miss Dr. Anderson's guidance, support and caring even more. I have lost a friend and a mentor. However, I am so glad that he accepted the position as my boss many years ago because he became so much more to me" said Odessa Ussery, Program Coordinator.

Dr. Anderson was a visionary for medical and continuing medical education. His professional legacy lies in the generation of physicians who learned clinical/surgical skills as well as his commitment to advance lifelong learning in licensed practicing physicians. He recognized the personal and professional challenges faced by physicians in their efforts to provide quality health care in a rapidly changing medical profession.

During his last 10 years as Associate Dean for Continuing Medical Education, Dr. Anderson expanded program offerings, advanced the quality of program content and expanded lifelong learning to research focusing on enhancing physician performance and overall health outcomes. His establishment of the South Carolina Medical Leaders Partnership Initiative would access leadership statewide to focus on health issues and concerns facing our state that could be addressed through CME. MUSC/CME also advocated providing CME credit to physicians who were involved in teaching/presentations to be able to receive credit for their efforts. This later was nationally adopted and implemented.

"Dr. Anderson made a difference in my life and was the ultimate mentor to me. He advanced my growth through development and did so with guidance and direction," said Dr. Jan Temple, Director of Professional Development in MUSC CME. "Our dialogue included agreements and disagreements that provided stimulation and growth. He was forward thinking, open to suggestions, and developed a team effort that made all feel as valuable contributors to the advancement

of CME. I most admired his vision and wisdom-it reflected a life balance that I aspire to achieve."

"Dr. Anderson was the most respectful, kind and generous boss," said Pam Benjamin, another Program Coordinator. "He was sure to compliment your good works and made you feel happy to be a part of his staff. His open door policy and readiness to listen and help was one that any employee would appreciate and value. It was quite an honor to work for Dr. Anderson and to get to know him and his family. His generosity and respect will never be forgotten."

"Dr. Anderson was one for whom I hold the highest degree of respect and admiration," said Valerie Morton. "He was a straight forward man regarding his needs, wants, and requirements as dean of CME. He was one of the easiest people to work for and be acquainted with. He will be sadly and greatly missed."

"I feel so very fortunate to have been associated with Dr. Anderson and to have been acquainted with his family," remembers Gerri Hollis. During his illness, he taught me humility and thoughtfulness of others by allowing me to feel useful and helpful to him and to his family. The loving and caring of people, he obviously taught his residents, was practiced daily with his employees and his family. Along with me, MUSC, colleagues, friends and family, we will all miss him! ***The world and MUSC is a better place because Dr. Marion C. Anderson chose to spend a part of his life here.***"

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Coming Events

RIME 2000

39th Annual Conference on
Research in Medical Education

**AAMC Annual Conference
and Society Fall Meeting**

Oct. 28-Nov. 2, 2000

Chicago, Illinois

<rimecom@aamc.org>

**Developing Expertise in
the Investigation and
Evaluation of Physician
Learning and Change
June 24-29, 2001**

University of Calgary HSC
Calgary, Alberta

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