

SAN FRANCISCO HOSTS SACME FALL MEETING

The 2002 SACME Fall meeting will be held November 8-11 in San Francisco in conjunction with the 113th Annual Meeting of the Association of American Medical Colleges. The SACME meeting will be held at the Westin St. Francis Hotel with the exception of the joint SACME/RIME session on November 10 that will be held at the Hilton San Francisco.

Those wishing to attend the Fall meeting must register for both the AAMC meeting and the SACME Fall meeting. Both registration processes can be accomplished on-line. The Web addresses for on-line registration are:

AAMC Annual Meeting: <http://www.aamc.org/annualmeeting>

SACME Fall Meeting: <http://www.sacme.org/registration.htm>

Melinda Steele, M.Ed., chair of the Program Committee for the Fall meeting recommends that Fall meeting attendees read two articles in preparation for the meeting:



- Bennett NL, Davis DA, Easterling WE Jr, Friedmann P, Green JS, Koeppen BM, Mazmanian PE, Waxman HS. Continuing medical education: a new vision of the professional development of physicians. *Academic Medicine*, 2000; 75(12):1167-1172.
- Repositioning the future of continuing medical education. A position paper from CMSS (Council of Medical Specialty Societies).

Both papers are available on the SACME Web site at: http://www.sacme.org/SACME_Meetings/Fall_2002/default.htm

Registrants are advised that due to the exceedingly high catering costs at hotels in the San Francisco area, refreshments will be kept to a minimum. This is a reflection on budgetary constraints and not level of enthusiasm or warmth of hospitality.

For schedule and program details, turn to page 3.

IN THIS ISSUE

From the President	2
JCEHP e-Version	2
Fall Meeting Schedule	3
Grand Rounds Certification	4
2003 Summer Research Institute	4
ACCME Competency Task Force.....	5
Best Practices: Interactive Lecturing.....	6
New Members.....	9
Membership Stats.....	9
News from the AMA	10
ACCME Internet Policy	11
Upcoming Events	12

SACME FALL MEETING

(in conjunction with the Annual Meeting of the Association of American Medical Colleges)

November 8-11, 2002
San Francisco, California

Westin St. Francis Hotel

FROM THE PRESIDENT

By Jack Kues, Ph.D.

There was a time, not so many years ago, when we struggled to get the world of medical education and health care to even talk about continuing medical education. The major topic at many of our meetings was how to get others to acknowledge our existence and listen to what we had to say. We have all seen the dramatic change in the last couple of years. Continuing medical education has been on the agenda of every major health care, medical education, and credentialing body in North America and beyond. This is rapidly becoming the realization of the old adage, "Be careful what you wish for." Several of our more prominent Society members have been in high demand as speakers and as appointees to various task forces, committees, and focus groups. Divisions and committees on CME have been created at the AAMC and other organizations. And several organizations have published vision statements for the future of CME to help guide major changes that they predict will occur in the next few years.

The work of the Society and its members over the last twenty-five years is now being more widely disseminated and discussed. The current light shining on CME has also created increased scrutiny and has opened a discussion on a number of critical issues including licensure, competence, certification, and life-long learning. The discussions cut across the medical education continuum, medical specialties, and credentialing organizations.

CME discussions have joined a larger arena and we must become familiar with broader issues in order to participate fully. Organizationally we are addressing the need for collaboration and education in a couple of important ways. Our Spring and Fall meeting programs have begun including speakers from outside the traditional CME circles. Many of the debates that we have been having within CME have also been occurring within other organizations and throughout the other parts of the medical education continuum. In November, the CME vision statement developed by Nancy Bennett and colleagues will share the dais with a presentation by Norm Kahn of the Council of Medical Specialty Societies vision for CME. In addition to the efforts by the Program Planning Committee, the SACME Leadership group is working with the board to develop more formal relationships with a number of organizations with connections to CME and medical education. As part of the latter plan we are in the process of identifying critical meetings and other events at which SACME

participation is important. This is an excellent opportunity for all members of SACME to help us build bridges, become more visible, and share information across organizations.



Most of us wear many hats in our jobs and we belong to organizations that could become partners with SACME. Please let me or a board member know about potential connections that we could make or, more importantly, a liaison role that you might be willing to play with another organization.

JCEHP E-VERSION AVAILABLE ON TRIAL BASIS

The Journal of Continuing Education in the Health Professions has been moving toward producing an e-version. The JCEHP Administrative Board has been working with BC Decker Publishing to have a full-text, searchable version of the journal available on-line as a subscription option. The latest issue of JCEHP contained a notice that current subscribers can sign up for a free trial period of the e-version. Access to JCEHP on-line can be obtained by visiting the www.bcdecker.com/signmeup Web site and completing a short form. The trial period runs from September 21, 2002 to December 31, 2002.

Access to the e-version of JCEHP will require users to sign in with a user identification and a password, which is designated by the user on the on-line application form. During the trial period, users will continue to receive the paper version of JCEHP. The JCEHP Administrative Board is currently negotiating with Decker to determine subscription access beyond the trial period. There are no plans at this time to stop the publication of the paper version of the journal.

INTERCOM

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Visit the SACME Web Site at
www.sacme.org

SACME 2002 FALL MEETING

SCHEDULE AND PROGRAM

FRIDAY, November 8	7:30 am - 12:00 pm	Board
	12:00 pm - 1:00 pm	Finance Committee
	1:00 pm - 5:00 pm	Research Workshop
	1:00 - 2:30 pm	Critical Appraisal of the Literature: How To Read a Paper <i>Barbara Barnes, M.D.</i>
	2:30 - 2:45 pm	Break
	2:45 - 3:30 pm	AAMC Guidelines for Manuscript Review Writing for Publication <i>Ann Steinecke</i>
	3:30 - 5:00 pm	Interactive Application Session
	5:00 pm - 6:30 pm	Research Endowment Council
6:30 pm - 8:00 pm	Program Committee (off-site dinner meeting)	
SATURDAY, November 9	7:30 am - 9:00 am	Members Continental Breakfast and <i>Intercom</i> Editors Meeting
	7:30 am - 9:00 am	Research Committee
	8:00 am - 9:00 am	Membership Committee
	9:00 am - Noon	General Session
	9:00 - 9:15 am	Opening Remarks
	9:15 - 9:45 am	CMSS Position Paper: Repositioning the Future of Continuing Medical Education <i>Norm Kahn, M.D.</i>
	9:45 - 10:00 am	Break
	10:00 - 10:30 am	A New Vision of the Professional Development of Physicians <i>Linda Casebeer, Ph.D., Ron Franks, MD</i>
	10:30 - 11:00 am	Panel Discussion of the Correlation of New Visions and Repositioning the Future of CME <i>Nancy Davis, Ph.D., Linda Casebeer, Ph.D., Ron Franks, M.D.</i>
	11:00 am - Noon	Best Practices
	1:00 pm - 5:15 pm	General Session
	1:00 - 3:00 pm	Best Practices and RICME
	3:00 - 3:15 pm	Break
	3:15 - 4:00 pm	RICME
	4:00 - 5:15 pm	HOT TOPICS: PhRMA Code and Task Force Update, Issues Regarding Grand Rounds for CME, CME Software Issues and Status, Other Topics
	5:15 pm - 5:30 pm	Break
	5:30 pm - 6:30 pm	Update/New Member Orientation
6:30 pm - 8:00 pm	Membership Reception	
SUNDAY, November 10	7:00 am - 8:45 am	Business Meeting
	9:00 - 10:00 am	Joint SACME/RIME Session
	*Hilton-Lombard	RIME Review Paper Presentation (<i>co-sponsored with the Society for Academic CME</i>) Moderator: <i>Barbara Barnes, M.D., University of Pittsburgh School of Medicine</i> The Aging Physician: Changes in Cognitive Processing and Their Impact on Medical Practice <i>Kevin Eva, Ph.D., McMasters University</i>
MONDAY, November 11	7:00 am - 9:00 am	Past Presidents' Breakfast

SIMPLIFYING THE CERTIFICATION PROCESS FOR GRAND ROUNDS

By Barbara Barnes, M.D., M.S.

Keeping grand rounds in compliance with accreditation requirements is an ongoing struggle for medical schools. A special survey of the SACME membership conducted last Spring indicated that needs assessment, program planning and evaluation are particularly problematic. At the Spring meeting in Charleston, Dr. Murray Kopelow presented data indicating that providers also have difficulty keeping grand rounds in compliance with the Standards for Commercial Support.

Medical schools have confronted these challenges in a variety of ways. Some have added staff to manage the paperwork. Others have curtailed the number of grand rounds certified or even eliminated CME credit for these activities. Unfortunately these strategies can have negative implications for the CME office, on one hand compromising its financial stability and on the other peripheralizing it from the core academic mission of the school.

Since the Spring meeting, SACME has been working closely with the Accreditation Council for Continuing Medical Education to clarify accreditation requirements as they pertain to grand rounds and develop strategies that will not only enhance compliance but also add to the educational effectiveness of these activities. In order to understand the breadth of issues, Dr. Kopelow conducted his own survey of a

sample of providers who certify grand rounds. These included not only medical schools but also hospitals and health systems. Based on this information as well as that obtained by SACME, the accreditation system has developed a concept statement delineating the expectations for compliance in regard to regularly scheduled series. At its July meeting the Accreditation Council endorsed the spirit of the grand rounds project. Dr. Kopelow will be presenting his document to a small group of providers for further feedback and in the near future will be promulgating it to the community at large for comments. SACME members will be used to develop viable strategies for the certification of grand rounds that meet the needs of the accreditation system, the CME offices, and, most importantly, the learners and organizations that we serve.

This project is symbolic of the collaboration and trust that have developed between SACME and the ACCME. The ability to provide feedback to the accreditation system and work cooperatively in the development of policies and processes results in regulatory requirements that are realistic to the environment in which they must be implemented and that focus on promoting educational effectiveness rather than fostering the collection of meaningless documentation. Thanks to all of you who have helped with this process and we look forward to receiving your feedback as we move ahead.

2003 SACME SUMMER RESEARCH INSTITUTE TO BE HELD IN NOVA SCOTIA

The next Summer Research Institute will be hosted by Dalhousie University Office of Continuing Medical Education, Halifax, Nova Scotia, June 22-27, 2003.

The institute is designed for both novice and experienced CME researchers. It enables participants to select learning activities of most value to them at their level of skill and knowledge. The goal is to assist attendees in completion of a project as a result of participating in the workshop.

Final program is pending, but plans include presentations on the core principles and process of educational research; mini-workshops to explore topics in depth and practice skills; individual consultation with skilled researchers about participants' proposals or studies; opportunity for participants to develop their own

research projects. Attendance will be capped at 30 participants to ensure an individualized experience for all registrants.

Late June is a wonderful time to be in Halifax. Potential participants are encouraged to attend not only to work and learn, but to enjoy the ambience of a friendly city, the sea breezes, beaches, and of course, the sea food!

Discounted registration fees will be available for SACME and Alliance for CME members.

The planning committee is chaired by Nancy Davis, Ph.D. and has the following members: Joan Sargeant, M.Ed.; Michael Allen, M.D.; Barbara Barnes, M.D., M.S.; Jack Kues, Ph.D.; Jan Temple, Ph.D., and Jocelyn Lockyer, M.H.A.

For further information, visit the SACME Web site, <http://www.sacme.org> for updates as planning proceeds; or contact any of the following planners:

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ACCME TASK FORCE ON COMPETENCY HOSTS MEETING OF CME STAKEHOLDERS

By Nancy Davis, Ph.D.

The Competency and the Continuum of Medical Education Task Force of the Accreditation Council for Continuing Medical Education hosted a meeting on July 10, 2002 in Chicago to which representatives of ten groups were invited to exchange information and have discussion with members of the task force. The participating groups were the Alliance for CME (ACME), American Academy of Family Physicians (AAFP), American Board of Medical Specialties (ABMS), American Medical Association (AMA), Association of American Medical Colleges (AAMC), Association of Hospital Medical Educators (AHME), Citizen Advocacy Center, Council of Medical Specialty Societies (CMSS) CME Directors, Federation of State Medical Boards (FSMB), and Society for Academic CME (SACME)

The Task Force asked representatives of each organization to address the issues of environmental changes in physicians' practice; the impact of those changes; how CME providers can respond; and what accreditation must value in order to support CME providers' new challenges. The presentations were followed by group discussion where several common themes emerged.

Workplace Learning: Physician performance assessment and resulting education will be most effective in the workplace, or physician's practice setting.

Maintenance of Certification: As specialty certification boards move toward maintenance of certification, CME providers will assume new responsibilities to assure physicians have the resources to meet these requirements. Life-long learning and self-assessment are key areas on which CME providers will focus. Specific competencies and curricula will be determined by specialty societies and boards, but will be made available by a variety of providers.

Self Assessment: A key component of maintenance of certification will be physician self assessment built on

competencies and board requirements. Physicians will need access to assessment tools and educational plans based on assessment results.

CME Relevant to Practice: There will be a focus on practice-based CME that is relevant to the individual. It will be not only specialty-specific, but practice-specific.

Content Validity: CME content must be evidence-based and delivered by qualified experts.

Credit System: There is much relevant learning taking place that is not recognized by CME credit. The credit "hour" is not appropriate for some types of learning.

Funding: Funding will be a challenge as we move to a more self-directed, learner-centered model.

The Task Force on Competency and the Continuum of Medical Education is a part of ACCME's continued effort to meet strategic imperatives set out in 2000. Members of the task force are Dorothy Lane, M.D., Chair; Errol Alden, M.D.; Bruce Koeppen, M.D., Ph.D.; and Ajit Sachdeva, M.D., FRCSC, FACS. The charge for the group is to identify a strategic agenda through which the ACCME:

- Can contribute to enhancing the effectiveness of medical education throughout the undergraduate, graduate, and continuing medical education continuum;
- Can identify opportunities for collaboration, cooperation, and synergy within the medical education community; and
- Can enhance the effectiveness of CME in the continuing professional development of physicians.

The group will synthesize information obtained from the July meeting and determine how improvements can be made in the accreditation system to meet new challenges in CME.

The SACME Board of Directors gratefully acknowledges an unrestricted educational grant received from CMEinfo.com in support of this issue of *Intercom*.



MAKING THE FORMAL LECTURE MORE INTERACTIVE

By Ivan Silver, M.D., M.Ed., FRCP (C), Professor and Director of Continuing Mental Health Education, Department of Psychiatry, Faculty of Medicine
and Darlyne Rath, R.N., BScN., MScT, Research Investigator with Knowledge Translation Program and Assistant Professor, Health Policy Management and Evaluation
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Background

The didactic lecture continues to be used in the delivery of formal continuing medical education (CME) programs, as it is still perceived to be the most effective, efficient method of sharing information with large numbers of people. However, Davis et al. conducted a systematic review of 14 randomized controlled trials of a variety of CME activities, both passive and interactive, and found that the didactic lecture alone is not effective in changing behavior or healthcare outcomes.¹ Additionally, a growing body of CME literature indicates that interactive continuing education sessions that include participatory activity can effect change in professional practice behavior, leading to an improvement in health care outcomes.¹⁻⁶

Based on research of the effectiveness of formal continuing medical education, CME providers are now encouraging presenters at CME events to give more interactive presentations. Barriers to interactive lecturing include the speaker's fear of giving up control of the content, an inability to cover the material, and a fear of not knowing the answer to questions by the audience. Steinert and Snell published a descriptive paper that is extremely helpful for those who wish to embark on interactive lecturing.⁷ The paper outlines the evidence for interactive lecturing as well as the barriers, and describes in detail the most common interactive lecturing techniques.

An interesting study conducted by Stuart on the concentration level of medical students during 50-minute didactic lectures showed that concentration rose steadily for the first 15 minutes and then declined toward the end of the lecture.⁸ Based on this study, it was recommended that lectures be no longer than 30 minutes.

In addition to the randomized control studies that are of medical clinical value, there is a body of qualitative literature that emphasizes the importance of interactivity to the learner. For decades, most experts in adult education and adult learning have advocated the active participation of learners.^{9,10}

To summarize, adult education experts believe that no one directly teaches anyone anything significant; people learn what they want to learn. When ideas are imposed on people, we are training them. When an atmosphere is created in which people are free to explore their ideas in dialogue and interaction, we educate them.

The evidence clearly emphasizes the need for interactive lecturing in the health care environment. When done effectively, interactive lecturing can increase learning, influence change in practice, and have a positive effect on health care outcomes.

Interactive Techniques

What is "interactivity" in large group lecturing and how can this be applied to a formal presentation? Interactivity in a lecture format can include interaction with the faculty, between members of the audience, and with the learning material. Several teaching techniques that enhance interactivity in large group lecturing are described below.



1. QUESTIONING THE AUDIENCE

There are several "questioning methods" that are useful at different stages of a lecture. Five of these methods are the use of: rhetorical questions, surveys, straightforward questions, brainstorming, and quizzes.

Think of starting a lecture with a rhetorical question. These are questions where no answers are expected; one uses this technique to grab the audience's attention. For example one might start a lecture on treatment-resistant depression by asking, "how many of you have sat in your office with a chronically depressed patient and felt almost as nihilistic about their prognosis as the patient?" The use of a "survey" might be added next. This technique can be useful to identify audience, characteristics, interests, and beliefs. The speaker might ask, "How many of you have treated

treatment-resistant depressed patients?” The presenter would then ask for a show of hands. This question could be followed by “how many of you have more than 10 of these patients in your practice? More than 20?” This technique personalizes the topic and engages learners. Straightforward questions can be interspersed throughout the lecture. For example, using the treatment-resistant depression topic, “what approaches have you taken to treat these patients?” Once a few of the members of the audience have responded, the instructor can re-organize the audience responses and present his/her approach to this problem.

The underlying premise behind these types of questions is that you are acknowledging the audience’s considerable knowledge about any topic that you are teaching. Audiences enjoy and appreciate being acknowledged in this way. Your role as a presenter can flexibly switch at times from “the all knowing transmitter of knowledge” to the facilitator who engages in a dialogue with the audience and helps organize information gleaned from the audience.

A related questioning technique is called brainstorming. This process entails creating a list of answers by the audience to a question posed by the teacher. For example, using the above lecture on treatment-resistant depression, one might ask for a list of all treatment approaches. The teacher would then type a list generated by the audience (using PowerPoint). The teacher generates the list uncritically and without comment. After the list is completed, the lecturer can help the audience organize the points into categories or invite comments from the audience. Brainstorming at the end of grand rounds can help organize the key points of a lecture or rapidly generate a list of questions to trigger the question period.

Quizzes (using multiple choice or short answer questions) before or after the lecture can help focus the audience on the key learning points and provide feedback on how well key issues have been learned. Allowing a few minutes to review the right and wrong answers at the end of a lecture is a nice way to finish the presentation before the question period. A playful addition to using multiple-choice questions is to make five color-coded cards attached at the bottom for each audience member (each of the five colors represents one of the choices in a standard multiple choice question). Audiences are then asked to vote by holding up the appropriate color signifying their choice (a, b, c, d, or e). The audience then is able to see how their peers “voted” and the teacher receives immediate feedback on the audience’s level of knowledge. A more sophisticated version of this can be achieved with an audience response system.

2. BREAKING THE AUDIENCE UP INTO SMALLER GROUPS



This technique can promote the discussion of ideas and problem solving during a lecture. This can be done in a variety of ways.

Using the example discussed earlier, the lecturer might ask the audience to first write down the strategies that they have used to treat resistant depression. After two minutes of reflection, the audience members can turn to their neighbor (pair) and share their ideas with them. After three minutes, the lecturer asks two or more of these pairs to share their discussion with the audience and then asks others for any other ideas that might not have been mentioned. This teaching technique is called write-pair-share and can be useful for large and small group teaching. A variation of this technique involves forming small groups within a lecture of 6-8 members of the audience. Three to four people sitting in one row turn around to face 3-4 people sitting in the row behind them. This last step can be used by itself or can be used as an “add on” to the write-pair-share. This is sometimes called “pyramiding”. The latter can be useful when some consensus of opinion from the group is desired. Although using small groups within a large group takes time, these techniques can help focus the discussion around key issues and can be very engaging midway through a lecture.



3. ENGAGING THE AUDIENCE THROUGH CLINICAL CASES

This time-honored teaching method helps engage learners to solve clinical problems that are imbedded in the case. During a lecture, the audience can be asked to “work through” a case. The lecturer can stop the case presentation at different points, asking the audience for input as the case unfolds. The lecturer can use straightforward questions that ask individuals to respond or alternatively use the write-pair-share technique or both interchangeably. A related case-method teaching technique is to assign parts of the audience a different perspective of a case or problem. A part of the audience has to present the arguments related to that perspective whether they agree with it or not. For example, during a recent lecture on ethical issues related to involuntary placement of a geriatric outpatient, the lecturer divided the audience into four groups representing the key “players” in the decision-making process. The four groups included the patient’s perspective, the caregiver,

society's and the long-term institution's point of view. The lecturer brainstormed a list of relevant issues to be considered from each group, reorganized them, and during a didactic presentation that followed, incorporated the audience ideas into her presentation.



4. SIMULATIONS AND ROLE-PLAYS

These are very effective techniques that help focus attention and increase the clinical relevance of a "case". The highest rated psychiatry grand rounds at my teaching hospital was a simulation of the review board process. An actual review board chairman and two legal aid lawyers participated. The "patient" was role-played by the hospital department chief and members of the multidisciplinary team played the members of the family. The simulation was successful because the actors took their roles very seriously. The rounds moderator acted as the discussant summarizing the critical issues for discussion in the last 15 minutes of the rounds.

5. WRITTEN MATERIALS



Written materials can help summarize key learning points, and they take pressure off the presenter to cover all of the material. Handouts can include a copy of the PowerPoint slides, additional relevant reading material, and references. Alternatively, the hard copy of the PowerPoint slides can be deliberately incomplete; this requires the attention and concentration of the audience to fill in the blanks. Another novel use of relevant reading material is to have the audience read a page of succinct material during the rounds (a period of silent reflection). Following this a "write-pair-share" exercise can generate discussion of the key learning points from the written material.

Summary

Interactive lecturing can enhance learning, attention and concentration and make the learning experience exciting and energetic. From the lecturer's point of view, changing from standard lectures to interactive lecturing is not a simple process. Most teachers will need to see interactive teaching techniques demonstrated or be "coached" before they feel comfortable changing their teaching style. Here is a brief guide to help you get started with your interactive lecturing career.

1. Interactive lectures take longer to prepare. An observed rehearsal is recommended.

2. Choose one interactive technique that seems most doable and try it out. Ask a trusted colleague for feedback.
3. Eventually, try and use three interactive lecture techniques per presentation.
4. If you use interactive lecturing, you will need to cut down the amount of your "material". Build your lectures around three or four key points.
5. You can learn to be an interactive lecturer. Once you learn a few techniques, you will never go back to monologues.

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MEMBERSHIP NEWS: SACME WELCOMES NEW MEMBERS

The Society for Academic Continuing Medical Education is pleased to welcome a number of new members to this organization. The following members have been confirmed:

Allan Abbott, M.D., Associate Dean for Postgraduate Education, University of Southern California, Keck School of Medicine, Los Angeles, California

Leslie Aguayo, Administrative Director, Office of Continuing Medical Education, University of California, San Francisco, School of Medicine, San Francisco, California

Zalman S. Agus, M.D., Associate Dean for CME, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania

Sherman J. Alter, M.D., Director, Continuing Medical Education, Wright State University School of Medicine, Dayton, Ohio

Bruce J. Bellande, M.A., Ph.D., Executive Director, Alliance for Continuing Medical Education, Birmingham, Alabama

Joanne F. Bond, M.S., Director of Continuing Medical Education, Roswell Park Cancer Institute, Graduate Division, Buffalo, New York

Kathy P. Bradley, Ed.D., OTR/L, Director Continuing Education, Medical College of Georgia, Augusta, Georgia

A. Wayne Bruce, Ph.D., Program Director, Continuing Medical Education, University of North Dakota School of Medicine & Health Sciences, Grand Forks, North Dakota

Bonnie E. Carroll, Director, CME, University of California Irvine, College of Medicine, Irvine, California

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Hassan Danesh, Ph.D., Director, Continuing Medical Education, Indiana University School of Medicine, Indianapolis, Indiana

Kim E. Davis, M.A., Director of Research and Education, Academy of Medicine of New Jersey, Lawrenceville, New Jersey

Stuart Gilman, M.D., M.P.H., Director, Health Profession Accreditations, VA Employee Education System, Long Beach, California

Summers Kalishman, Ph.D., University of New Mexico School of Medicine, Office of Program Evaluation (PEAR), Albuquerque, New Mexico

Brent Kvern, M.D., C.C.F.P., Associate Dean, Continuing Medical Education, University of Manitoba, Winnipeg, Manitoba, Canada

Robert J. Malcolm, M.D., Associate Dean of Continuing Medical Education, Medical University of South Carolina, Charleston, South Carolina

Michael Marrin, M.D., FRCPC, Assistant Dean Continuing Education Programme, McMaster University Faculty of Health Sciences, Hamilton, Ontario, Canada

Geno J. Merli, M.D., Senior Associate Dean for CME, Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania

Tristan M. Nelsen, M.N.M., CME Program Manager, University of Medicine & Dentistry of New Jersey, Newark, New Jersey

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Pauline Sylvester, M.B.A., Senior CME Associate, Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania

Anne Taylor-Vaisey, M.L.S., Reference Department, C.C. Clemmer Health Sciences Library, Canadian Memorial Chiropractic College, Toronto, Ontario, Canada

Timothy J. VanSusteren, Ph.D., Associate Dean for Continuing Medical Education and Faculty Development, University of Florida College of Medicine, Gainesville, Florida

SACME MEMBERSHIP STATISTICS

The Society's Executive Secretariat is currently processing membership renewals for the 2002-2003 year. The following applications/renewals have been received:

- 122 Voting Members
- 14 Emeritus Members
- 5 Continuing Members
- 6 Honorary Members

Thus, the total 2002-2003 roster includes 147 members as of September 12, 2002. Fifty-eight membership renewals are still outstanding. The Secretariat urges all members who have not yet sent in dues payment for 2002-2003 to do so as soon as possible. Dues payments can be made using a credit card on the Web site, <http://www.sacme.org>.

For any questions regarding membership, contact the Executive Secretariat by phone at (205) 978-7990.

NEWS FROM THE AMERICAN MEDICAL ASSOCIATION

TOWARD THE FUTURE: DEVELOPMENT OF A GLOBAL APPROACH TO CME AND CPD



By Dennis K. Wentz, M.D.

Beset with all the problems all of us face in just the everyday delivery of continuing medical education (CME) in the United States, it is easy to ignore what is happening in the rest of the world. The value of continuing professional development (CPD) for practicing physicians is as important in Europe or the Far East as it is in our country. While the precise definition and characterization of CPD varies, there is considerably more agreement on the elements of quality CME. From our vantage point at the American Medical Association (AMA) the pace of events in global CME is breathtaking. The interest in a credit system such as that of the AMA PRA program is intense and we are trying to deal with these global inquiries in a helpful and enlightened fashion.

The AMA's active participation in global CME dates to 1990, when, responding to member requests, the AMA House of Delegates approved the start of an AMA program to recognize qualified international congresses for AMA PRA credit under the umbrella of the AMA's stewardship of the AMA PRA program and credit system. Acknowledging that these world congresses often represent the state of the art and the "cutting edge" of medical science, and that U.S. physicians value these activities, our division established rigid criteria for approval of international scientific meetings. Following the meeting, which is monitored by an AMA representative, we then award AMA PRA category 1 credit for U.S. physicians who document their participation.

From this simple beginning, initiated for American physicians traveling to medical education activities overseas, we have observed a mushrooming global interest in CME. As a result of the 1990 AMA initiative, discussions began in 1996 with the European Union of Medical Specialists (UEMS). The UEMS, an organization of 34 specialist sections and 17 countries headquartered in Belgium, represents the specialist physicians of Europe. In 1998 the UEMS and the AMA signed a "Letter of Intent" to work together to develop global standards for CME credit. The concepts developed were then organized into a pilot project for International CME credit in 2000 (under the guidance of the AMA Council on Medical Education). Under the terms of the pilot, credit reciprocity

was established between the European system and the AMA PRA system. Only "live" activities are currently recognized in the European system and only a subset of these activities is also recognized as "international" in scope. Those so recognized are then registered with the AMA so those American physicians attending can have their "Euro credit" recognized as equivalent, and converted to AMA PRA credit if they apply. Most recently, we have also had direct contact with the Spanish Medical Association (SMA). This October we will sign an agreement with the SMA for assistance in developing a unique Spanish CME credit system. (The SMA is also planning to sign an agreement with the ACCME for assistance in a planned system of accreditation of providers.)

Many other global discussions about credit equivalency are also under way. A major focus is on Central America, where in 1996, acting in the spirit of the North American Free Trade Agreement (NAFTA), the AMA opened eligibility for the AMA PRA to licensed Mexican and Canadian physicians. Discussions are now under way with medical authorities in this region to establish shared standards for the awarding of CME credit.

Other discussions are also under way, including the far Pacific. I have just returned from a trip to South East Asia where several countries are moving toward systems of mandatory CME. In all of them, it is the medical associations of those countries, often working in parallel with government, that are leading the way to help establish and provide quality CME. We have been able to share with them the observations of AMA's 34 years of experience with a credit system. There is keen interest in establishing the conceptual basis for a system of international CME credit that will be universally recognized.

In other developments, the 2002 annual meeting of the Association for Medical Education in Europe (AMEE) had several sessions on CME and CPD. AMEE brings together the medical schools of Europe, and has had little interest in the roles of medical schools and CME in the past. One session highlighted the varied roles that U.S. medical schools play in CME and demonstrated to our European colleagues how

academia can guide CME and CPD and serve societal needs. Presentations came from several U.S. medical schools: Alabama, Duke, Stanford, University of Wisconsin, as well as schools in Latin America and Canada. Finally, in October, we have been invited to serve on a special Committee on International CME standards at a meeting organized by the World Federation of Medical Education (WFME). In the past the WFME has focused almost exclusively on undergraduate medical education.

This brave new global world of CME was never imagined when the AMA PRA program was launched in 1968. Because of these developments, we have had to clarify that the awarding of AMA PRA category 1 credit by U.S. providers is limited to U.S. licensed physicians, unless, as explained in the new AMA PRA information booklet, the AMA has approved the activity in advance for international attendees.

We felt compelled to address this matter because major sensitivities exist at this formative stage on the global scene.

Currently, most governments and regulatory bodies have no concept of the U.S. system. We believe it important that we not “push” AMA PRA credit on other parts of the world. While it is possible that AMA PRA credit will someday be universally accepted, it is more likely that a new system of “international” credit will need to evolve, based on shared global standards for quality CME. As of this Fall, the AMA will notify and inform other countries with whom we are in contact (medical associations, regulatory bodies, government) when AMA PRA credit is likely to be awarded to their physicians. It may be appropriate to refer a U.S. accredited provider to one of these bodies.

Thus, our world of CME has become global, and there is worldwide interest in defining standards for CME that will be recognized internationally for the awarding of CME credit. Only by cooperating with these forces will we adequately serve the doctors of the world. Credit reciprocity is no longer a hypothetical issue: it is moving rapidly toward reality.

ACCME INTERNET POLICY BECOMES EFFECTIVE OCTOBER 1

The Accreditation Council for Continuing Medical Education’s new Internet policy became effective on October 1, 2002. As of that date, all Internet activities must be in compliance including those that are currently certified and those that are newly certified.

The policy states that:

- CME activities delivered via the Internet are expected to be in compliance with ACCME Essential Areas, Elements, and Policies.
- There shall be no CME activities of an ACCME accredited provider on a pharmaceutical or device manufacturers’ product Web site.
- With clear notification that the learner is leaving the educational Web site, links from the Web site of an ACCME accredited provider to pharmaceutical and device manufacturers’ product Web sites are permitted before or after the educational content of a CME activity, but shall not be embedded in the educational content of a CME activity.
- Advertising of any type is prohibited within the educational content of CME activities on the Internet including, but not limited to, banner ads, subliminal ads, and pop-up window ads.
- The accredited provider must indicate, at the start of each Internet CME activity, the hardware and software required for the learner to participate.
- The accredited provider must have a mechanism in place for the learner to be able to contact the provider if there are questions about the Internet CME activity.
- The accredited provider must have, adhere to, and inform the learner about its policy on privacy and confidentiality that relates to the CME activities it provides on the Internet.
- The accredited provider must be able to document that it owns the copyright for, or has received permissions for use of, or is otherwise permitted to use copyrighted materials within a CME activity on the Internet.

Newsletter of the Society for Academic
Continuing Medical Education
3416 Primm Lane
Birmingham, AL 35216

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UPCOMING EVENTS

October 12-13, 2002

“Changing Physicians’ Clinical Behaviors: The State of the
Science, the State of the Art”

Sponsored by University of Wisconsin Medical School and
the Office of Continuing Medical Education

Madison, Wisconsin

Contact: Mary L. Hughes (608) 265-4022

October 16-19, 2002

International Conference on Physician Health
“Physician Health: Self, Service, Leadership”

Sponsored by the AMA and the Canadian Medical Association
Vancouver, BC, Canada

Contact: Roger Brown, Ph.D. (312) 464-5476 or
roger_brown@ama-assn.org

November 1, 2002

IACME 2002 Workshop II: Preparing for Your ACCME Inspection

Oak Brook, Illinois

Contact: Nancy Bashook (847) 733-1750

November 8-13, 2002

SACME Fall Meeting

Association of American Medical Colleges

San Francisco, California

Contact: Jim Ranieri (205) 978-7990

January 29-February 1, 2003

2003 Alliance for CME Annual Conference

Dallas, Texas

Web site: <http://www.acme-assn.org>

February 28-March 1, 2003

Understanding ACCME Accreditation

Chicago, Illinois

Contact: Becky Flanigan (312) 464-2500