The Society for Academic Continuing Medical Education

INTERCOM

THE SOCIETY FOR ACADEMIC CONTINUING MEDICAL EDUCATION

SACME 2003 Fall Meeting Program Highlights Major Issues Facing CME

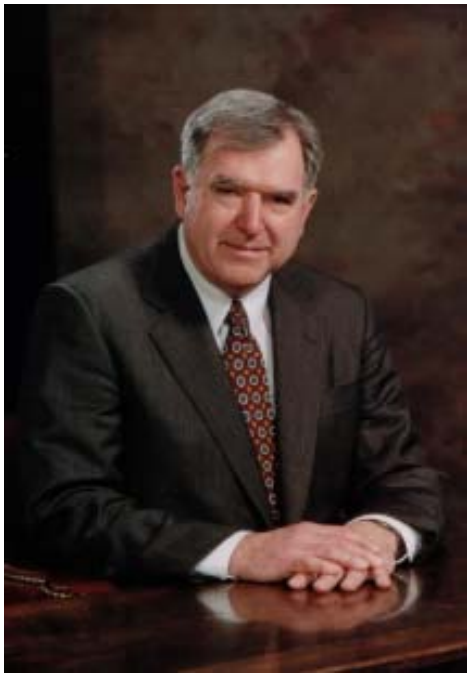
Time is running out to register for the Fall Meeting of the Society for Academic CME to be held in conjunction with the annual meeting of the Association of American Medical Colleges (AAMC) in Washington, D.C. The SACME meeting will be held from November 7-10, 2003 at the Hilton Washington Hotel.

Highlights include a research workshop on designing effective questionnaires and the latest updates on important CME issues. Generating a lot of anticipation is a presentation by Arnold S. Relman, M.D., Editor-in-Chief Emeritus of the *New England Journal of Medicine*, on "Funding of Academic CME and Commercial Support." This presentation will be followed by the Washington Legal Foundation's position on the ACCME's proposed revision of the Standards for Commercial Support. To make the most out of this plenary session, program organizers urge registrants to read the articles listed under "suggested reading" on the SACME web site prior to the session.

The Hot Topics sessions will include how commercialism and shifts in funding impact the uncertain future of CME; use of funding for CME by pharmaceutical representatives to influence institutions; a progress report from the "Terrorism in CE Task Force on Rapid Deployment CE"; and some new information from the American Medical Association on CME credit for residents and fellows.

Also on the program is a session jointly sponsored by SACME and the Group on Educational Affairs CME Section of the AAMC called "SARS: Lessons for CME" that will include Lee Manchul, M.D., Dave Davis, M.D., and Barbara Barnes, M.D. as speakers.

Social events include a reception recognizing SACME's past presidents followed by an optional dinner honoring past presidents to be held at DC Coast, a highly-rated Washington, D.C. restaurant. Dinner tickets are not included in the registration fee.



Arnold S. Relman, M.D.

The Fall meeting provides a unique opportunity for CME professionals to learn about and interact with all their CME colleagues as well as all segments of the educational continuum.

Additional information about the program as well as registration materials can be found on the Society's website at http://www.sacme.org. It is important to note that registration to the AAMC is also required since name badges and credentials for entrance to all events are being issued via the AAMC.

In This Issue

From the President

Beating Regulation With Evidence and Quality Improvement

By Nancy Davis, Ph.D.

I am writing this immediately upon my return from the 14th Annual Conference of the National Task Force on CME Provider/Industry Collaboration (could it *have* a longer title?). Suffice it to say the focus of the conference this year was on regulation. The Office of the Inspector General's (OIG) Compliance Program Guidance for Pharmaceutical Manufacturers is the newest "guidance" of concern to the CME industry. It is added to the long list that includes ACCME Standards for Commercial Support; AMA Council on Ethical and Judicial Affairs (AMA CEJA) guidelines for gifts to physicians; and the Food and Drug Administration (FDA) guidance for CME. CME providers and industry supporters alike have the burden of interpreting this plethora of regulation, some of which conflict with others. In typical American style, the industry and the government have responded to each new perception of impropriety with new rules. Unfortunately, creativity has been redirected from innovations in CME programming to responding to regulation as the pharmaceutical industry and CME providers attempt to sort through it all and determine how best to protect themselves.

The motivation for most CME regulation is to assure high quality CME without commercial bias. Virtually all the regulations promulgated by the organizations listed above came about as an attempt to eliminate inappropriate influence on physicians by the pharmaceutical industry. There is, however, great opportunity for CME providers and industry to collaborate toward the same end in compliance with regulation and provision of high quality, effective CME for physicians. That opportunity comes with the linkage of science, CME and quality improvement.

Quality improvement (QI) in practice has received much attention since the first Institute of Medicine report on medical errors and patient safety. Many physicians don't have the skills needed to integrate quality improvement plans into practice. Identifying needed changes in practice, measuring current practice against evidence-based benchmarks, implementing interventions, and re-measuring provides physicians with relevant, practice-based change leading to improved patient care. CME that includes a QI component will assist physicians in making these changes. Physicians need evidence-based CME that includes valid clinical guidelines and practice recommendations along with the tools to implement them.

What does all this have to do with preventing commercially biased CME? If CME is truly evidence-based and relevant to practice, the risk for commercial bias is decreased significantly. Industry can provide data, experts and funding for CME, but content must come from evidence that is critically appraised. Strength of evidence and its source must be disclosed to learners. Learners have the responsibility to assess the CME they consume and implement recommendations appropriately for their own patients.

Academic CME is beautifully positioned to carry out this new model of CME. We develop and deliver CME from an environment where valid content is respected and expected. We need commercial support to continue our programs, but we have a professional obligation to assure content that is scientifically sound.

We will have an opportunity to continue the discussion of the coexistence of commercial support and continuing medical education at the SACME Fall meeting November 7-10 in Washington D.C. Dr. Arnold Relman and Richard Samp will offer two views of these relationships. And, of course, we will hear about regulation from the American Board of Medical Specialties, the Federation of State Medical Boards and the Liaison Committee on Medical Education. Don't allow yourself to be overwhelmed. Look for opportunities to shine in a time when science and quality improvement will ease the regulatory burden. I look forward to seeing you in Washington!!

Intercom

Intercom is published three times a year by the Society for Academic Continuing Medical Education, Executive Secretariat Office, 3416 Primm Lane, Birmingham, AL 35216; Telephone: (205) 978-7990; Fax: (205) 823-2760.

The views expressed in *Intercom* are those of the authors and are not intended to represent the views of SACME or its members.

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CME Congress 2004: You *Belong* in Toronto

By Dave Davis, M.D., CME Congress 2004 Chair and R. Van Harrison, Ph.D., CME Congress 2004 Program Chair

Preparations for Congress 2004 are in full swing. This Congress, sponsored in part by the Society for Academic Continuing Medical Education and hosted by the University of Toronto, will be held May 15-18, 2004 at the Fairmont Royal York Hotel, in Toronto, Canada.

This event is guaranteed to provide participants with tremendous educational, networking, and social opportunities. CME Congresses, held approximately once every four years, are unique events, bringing together a wide range of organizations and individuals involved in CME to share innovations, research findings and experiences. Congresses have helped *shape* CME.

The title of Congress 2004 is "Linking Information, Education, and Implementation: How CME Helps Translate Knowledge into Practice". The five main themes of the Congress—information, education, implementation, regulation, and health care environment—were selected to reflect the various aspects of knowledge that are critical to its effective usage. Widely recognized speakers have committed to making presentations, each related to the above themes, at the plenary sessions. However, the majority of time is devoted to *learning from each other*, and we're currently accepting submissions for papers, symposia, and workshops, which are due October 15, 2003; the submissions for posters are due February 1, 2004. This variety of breakout formats provides a selection of ways to be involved, and also for diverse learning opportunities.

Toronto offers a rich blend of ideas, shops, art and cuisine. Spring is a wonderful time to enjoy its unique cafés, clubs and restaurants along the streets of its many ethnic neighborhoods. Take a stroll along the lakefront or a ferry across the lake to Toronto Island; visit the CN Tower; catch a game at the SkyDome; see a play or a musical in the theater district; take a half-day to visit Niagara Falls. There are excellent exhibits at The Science Centre, the Royal Ontario Museum and the Art Gallery of Ontario, and they all provide activities for children. Its diversity makes Toronto the ideal place to hold an international meeting.

The gracious off-white building in the midst of the office towers is the landmark Royal York Hotel. Refurbished guest rooms and suites, and a fully-stocked Business Centre are some of the recent changes, while many of the hotel's distinguishing features are still intact – the magnificent hand-painted ceilings, the travertine pillars, ornate furnishings, crystal chandeliers, and wall hangings.

The relevant and multifaceted nature of the Congress themes will appeal to a broad range of individuals from the United States, Canada, and internationally, including CME planners, health services researchers, policy-makers, leaders in organized medicine, physicians and other health care professionals, quality improvement professionals, and health educators. In addition, involvement of the members of SACME, ACME, AHME, and the attendance of many others suggests a strong networking potential. This Congress has been organized to encourage participant discussion, which will hopefully lead to a smoother transition from research and theory to actual practice, as well as to future collaborative efforts.

The Congress 2004 website http://www.cmecongress.org provides more detailed information about the program, speakers, submission of abstracts, registration, and accreditation. Please refer to this site or contact the organizers at:

Email: ce.med@utoronto.ca
Telephone: 416-978-2719
Toll-Free: 1-888-512-8173
Fax: 416-971-2200

Watch for program news in future issues of *Intercom*.
Looking forward to seeing you in Toronto in May 2004…you *belong* here!

Case Study

Developing the Double Helix of Practice Based Learning and Improvement

By Martyn O. Hotvedt, Ph.D., Associate Professor, School of Medicine, Pennsylvania State University, Director of the Center for Educational Development and Support, Lehigh Valley Hospital and Health Network, Allentown, Pennsylvania and Robert J. Laskowski, M.D., M.B.A., President and Chief Executive Officer, Christiana Care Health System, Christiana, Delaware

The mission of a community-based teaching hospital is to help people within the area it serves achieve and maintain optimum health status. Ten years ago the Board of Trustees of the Lehigh Valley Hospital and Health Network (LVHHN), a major affiliate of the School of Medicine, Pennsylvania State University, recruited a new President and Chief Executive Officer (CEO) to administer its multicampus, community-based, teaching hospital. Within the first two years of his tenure, he brought a new Chief Medical Officer (CMO) on board and, in conjunction with the board, a strategic plan was developed to build the new and expanded LVHHN.

During the planning process the CEO conceptualized the metaphor of a tricycle to best illustrate the hospital's strategic vision, transforming the university metaphor of a three-legged stool into a more action focused one that symbolizes a community hospital with strong academic underpinnings. The university's three-legged stool represents research, education, and service whereas the tricycle metaphor is focused on the practical nature of patient care as the core of a community-based hospital.

The tricycle has a large front wheel, representing the magnitude of patient care, which is the ultimate reason for the existence of a hospital. The rear wheels are medical education or continued learning paired with clinical research and inquiry leading to quality improvement. Given that the mission of LVHHN is to help the people of the Lehigh Valley achieve and maintain optimum health status and that the useful metaphor of the tricycle is to help guide the strategic plan for the development of LVHHN, a tactical plan was conceptualized by the leadership team using education and research to improve and enhance patient care.

The vision for the educational "rear wheel" of the tricycle was to develop a learning culture through support and development of educational activities. Toward this end, the Center for Educational Development and Support (CEDS) was established. The mission for CEDS is to facilitate development of a premier academic community hospital through building of a learning organization. The goal is to develop a culture to support all clinical professionals in their growth as life-long learners and continuous problem solvers.

The educational units of LVHHN, under the umbrella of CEDS, are responsible for all aspects of medical education including medical students and clinical residents; nursing education, including nursing students and nursing staff development; continuing health practitioner education, including CME; faculty development; patient education; and support services including the library, audio visual, classroom, teleconferencing and educational technology. Bringing all these units under one umbrella has helped facilitate the development of a learning culture, turning LVHHN into a learning organization.[1]

The Board of Trustees and the leadership team established a strategic plan that focused on improvement, innovation, and service to be accomplished through the building of the learning culture. Led by the CMO, it was determined that changing the culture required focusing on shared values and expected behaviors. Initially, values such as learning, innovation, compassion, service, creativity, and excellence were delineated along with expected behaviors including collegiality, civility, honesty, cooperation, effectiveness, and efficiency to encourage clinicians to focus on the new vision. Seven roles were highlighted to incorporate these values and behaviors into everyday life: to be a health advocate for our patients; to be a clinical innovator in all aspects of health care; to be a champion of quality in everything we do; to encourage continuous learning; to always be a teacher and educate those around us; to be a leader in the community; and also to be a servant to the community. These roles are intended to incorporate new values and behaviors expected in a learning culture.

To succeed with the tactical plan required a large number of educational activities involving many clinical staff members. The charge of the Board of Trustees to become a learning organization encouraged everyone at LVHHN to focus on the direction they needed to move in, but the plan was not enough. Day-to-day educational activities need to change in order to reinforce the overall process and specific support is necessary to help individuals actually change behaviors and attitudes. Because this was so important to LVHHN, generous funding from the institution and from external grants was obtained and a number of educationally

related projects were developed and carried out involving numerous clinical professionals.

Traditional continuing educational activities were conducted as first steps, including bringing national speakers to the Lehigh Valley to address large groups of health care professionals. Support was also provided to individual health care professionals to attend national and regional continuing education activities. It was quickly concluded that the large group activities were not very successful in changing the culture, but rather reinforced the status quo. Encouraging individuals to attend national and regional continuing education activities was useful, but having those individuals share what they learned with their peers has proved to be invaluable.

Research we conducted indicated that practicing clinicians perceive that their best learning opportunities occur when they are solving practical problems, either by themselves or in small groups.[2] Some of the small groups' problem solving educational activities included the development of practice paradigms built within specific domains in order to help clinicians provide better care. It became clear that individual and small group educational activities were more effective in building a learning culture than traditional methodology.

We have now categorized our small group educational activities as Communities of Practice (CoP).[3] In building these CoPs, we used the following guidelines: (1) each CoP activity is made up of a closed group of health care professionals who have membership in the group; (2) these individuals have a minimum level of knowledge in the shared domain of the educational activity; (3) they engage in joint activities, such as discussions which are both synchronous and asynchronous, helping each other and sharing information; and (4) they develop a shared repertoire of resources such as sharing experiences, stories, tools, ways of addressing reoccurring problems and at least in this area they develop a shared practice.

Each CoP uses the model of focused continuing education we developed as a methodological guide. Focused continuing education usually includes the following steps: (1) identify an important clinical problem, (2) develop outcome measures for success of the improvement, (3) determine baseline information about the problem, (4) analyze the baseline information, (5) develop and implement a change strategy, and (6) measure the progress of the change strategy toward the improvement of the problem. Using this structure, small groups of health care practitioners work together to solve practical, everyday problems in their practice and help each other continue to learn and grow which continually improves our learning culture.

Although we all recognize learning as an individual activity, emphasis on individual learning is not usually rewarded by national accreditation systems. Our focus on individual learning activities through the adaption of Personal Learning Projects developed by The Royal College of Physicians and Surgeons in Canada has emphasized this different approach to education.[4] It has reinforced the idea of the development of a learning culture through the support of individual learning, focused on continuous improvement of one's problem solving ability.

The development of our learning culture at LVHHN can best be described as the double helix of practice based learning and improvement. One strand of the double helix is our small group learning activities (CoPs). The other strand is the individualized educational activities which we have dubbed "personal learning projects." We found that in the educational activities that have been successful in developing our learning culture, the two separate strands are connected. For example, our CEDS Senior Fellowship Program has five Fellows who each spend two years on an individual educational project that will improve their clinical department. These individual projects initiated by each Fellow involve small groups of faculty members in their department who carry out the educational project. Each Fellow also works with Fellows from other departments to focus on the methodology, creating a camaraderie and support system which reinforces something new and different—our learning culture.

Another example of the double helix at work is the CoP in the Emergency Department. The CoP focuses a group of emergency medicine doctors and nurses on day-to-day improvements within the department by relying on the individual initiatives and learning of all members. Another example is the Physician Leadership Program of the Lehigh Valley that focuses on individual learning as well as small group learning. Thus, the two strands of educational activities, CoPs and personal learning projects, work hand in hand to support each other, reinforce each other, help the individuals grow and develop, and help establish LVHHN as a learning organization.

The two strands form the double helix by involving active participation. Individuals and small groups actively pursue problem solving and the discovery of new knowledge that does not readily occur when the health care professional is passively sitting in an auditorium receiving information from the lecturer.[5]

The link that holds the two strands together can best be described as reflection.[6] The learners (problem solvers) reflect on issues involved. When reflections and possible solutions are shared with members of the small group, the group aids in the determination of the solution. The group members are collectively more effective than any one individual's ability to solve the problem. Group involvement provides the individual greater opportunity for self-evaluation by allowing for comparison to other members in the group. In addition, the individual feels responsibility toward the group and to participate fully. The group ponders the current problem through the interaction of individual reflections presented by the members, and develops solutions to problems. Thus learning continues. Since this is a very natural process, the double helix of practice based learning and improvement flows smoothly. We have managed to dissect this process in a way that has been extremely helpful in the building of our learning culture. By developing meaningful projects for individual health care professionals to contemplate and by providing small group structures to develop group meditation, many members of our clinical staff are continually improving their practice and actively becoming part of the learning culture.

In summary, from this case study it can be postulated that the goal of building a learning organization requires (1) senior leadership that highly values the goal of developing a learning culture; (2) educational activities which promote active involvement and are new, different, or somehow out of the ordinary, and (3) an interconnective process of reflection that ties together individual life-long learning with small group practical problem solving.

Why is this case study important to SACME members? In order for this study to have broader applications, the methodology to build the double helix must be enhanced by improving the processes of individual learning and small group CME. How can we encourage reflection to be most effective? How do we give leadership effective tools to improve the learning culture? Members of SACME are best qualified to conduct the applied research necessary to improve the double helix concept. By working with their affiliated teaching hospitals they can provide the leadership to help physicians really learn how to solve clinical problems effectively. Members of SACME who would be interested in pursuing this line of applied research with the goal of developing funding sources to support this more tailored approach to CME should contact Martyn Hotved, Ph.D. at (610) 402-2501 or martyn.hotvedt@lvh.com.

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SACME Completes IRS Review

By John Boothby, M.S.W., Treasurer

In September, 2002 the Internal Revenue Service notified SACME that it had been "selected" to undergo a "routine" review of its status as a non-profit organization. Assurances were made that the IRS periodically samples existing non-profit organizations for such standard reviews. Since the period of review extended back into the tenure of the previous treasurer, Arnold Bigbee at Mayo Foundation in Rochester, Minnesota, the process by necessity included some commitment of time and effort on Arnie's part to be interviewed by the IRS agent in charge of the review. Coincidentally, the IRS office conducting the review was located in Minnesota.

The IRS review included items as far-ranging as articles of incorporation, by-laws, business operations, sources and uses of funds, membership categories, and even publications and website content. Arnie's generosity with his time and patience with the IRS agent certainly facilitated SACME's successful completion of the review. The agent actually took up residence in Arnie's office at Mayo for two days, pouring over boxes of records that had been shipped back to Mayo for the review.

In April, 2003 the IRS notified SACME that they were confirming its continuing status as a non-profit organization. On behalf of the SACME Board, I formally conveyed our heartfelt thanks to Arnold Bigbee, along with a gift representing our gratitude, for his "re-enlistment" to the SACME ranks during this time.

SACME Research Institute Provided Unparalleled Experience for Attendees

The Society for Academic Continuing Medical Education held its Summer Research Institute, "Developing Expertise in the Investigation and Evaluation of Physician Learning and Change," at Dalhousie University, Halifax, Nova Scotia, Canada, June 21-25, 2003. Twenty-six registrants from CME offices across North America (13 Canadian and 14 American) attended the Institute, along with faculty with expertise in a variety of topics. A number of Society members participated as faculty, including Craig Campbell, M.D., Nancy Davis, Ph.D., Martin Hotvedt, Ph.D., Jack Kues, Ph.D., and Michael Allen, M.D. and Joan Sargeant, M.Ed., who were also the two Dalhousie CME hosts. Dalhousie faculty also included Blye Frank, Ph.D., Jean Gray, M.D., Karen Mann, Ph.D., Patrick McGrath, Ph.D., Eric Mykhalovskiy, Ph.D., and Peter Twohig, Ph.D.

As in the past, the main objectives of the Institute were two-fold. The first was to provide a sound and practical foundation in CME research for those relatively new to the field. The second, for those more experienced, was to provide a review of important concepts and practices, and the opportunity to consult with a mentor in areas of personal research interests and to work on one's own research study. Based upon a needs assessment of registrants, the mornings consisted of interactive presentations on general research topics, including framing the research question, research designs, quantitative and qualitative research methods, and using mixed research methods, the latter an approach frequently used in CME research. Smaller concurrent workshops on more specific topics such as using clinical and other objective data in CME research, critical appraisal of the literature, and conducting focus groups made up the afternoon sessions. Time was allocated to consulting with faculty mentor experts or working on one's own. The consensus of participants and faculty alike seemed to be that the mix of faculty and varied learning experiences contributed to learning for all, regardless of level of expertise.

A third and equally important objective of the Institute was to foster networking and collaboration. Since CME researchers in North America are a relatively small group of professionals, enabling opportunities for sharing research interests, learning from each other, and developing professional relationships which will extend long beyond the duration of the Institute were a priority of the Institute.

The final objective of the Institute, but by no means the least, was to have fun. As experienced adult educators, we are aware that a comfortable social setting contributes to learning and networking. To this end, the Institute began with an informal BBQ for registrants and faculty at Dalhousie on Saturday night. A cruise of the waters of Halifax Harbour and dinner on board a sternwheeler, the *Harbour Queen,* occurred on Sunday night. Since Sunday was also the longest day of the year, the group was treated to a wonderful summer evening and sunset over the water. Monday gave a well-deserved evening off.

Participants in the SACME 2003 Summer Research Institute posed for a group picture. They are, from left to right: first row, Susan Rock, Patricia Payne, Douglas Sinclair, Laurie Snyder, Joan Sargeant, Suzanne Ferrier, Jatinder Takhar, Lisa Wells; second row, Marianne Xhignesse, Karen Mann, Laurie Clayton, Tracey Wolfe, Susan Sawning Hall, Anne Murray, Laurie Perrier; third row, Derek Warnick, Craig Campbell, Teelina House, Nancy Davis; fourth row, Terri Kramer Moore, Don Moore, Tessa Trasler; fifth row, Allison Rentfro, Sylvia Scherr, Maria Wowk, Jack Kues; sixth row, Francis Kwakwa, Curtis Olson, Cathy MacDonald; and seventh row, Marty Hotvedt. Not pictured are Michael Allen, Connie LeBlanc, Lynne Haslett, and Angela Stone.

Tuesday evening offered a choice of a walking tour of historic Halifax or sailing on Bedford Basin in several smallish boats (a windy evening and lots of excitement for both sailors and landlubbers) followed by a feast of mussels, a BBQ for all, and a lively bus ride home.

At the end of the Institute, registrants appeared positive about their experiences. Asked how SACME could most help them in their efforts to continue to enhance their research skills and increase research activity as they returned home, responses were almost unanimous. At the top of their lists were the active facilitation of ongoing networking and mentoring opportunities to encourage the "translation of research theory into practice" in their work settings and encouragement to conduct research when other work priorities compete for scarce time and resources. Assisting with activities such as these may indeed be a new and important role for SACME and a discussion of how to do this will be on the agenda for the Fall meeting.

"This was very well organized and I had a great time! This surpassed my expectations of what I was hoping this Institute would do for me," said one participant. "One of the best conferences I have attended…acquisition of knowledge, skills and networking, as well as social aspects, were an asset," said another.

"Not only were we able to benefit from the experience within the SACME executive, we were able to draw on our own stellar faculty," said Joan Sargeant, M.Ed., Director of Program Development & Evaluation in the Division of Continuing Medical Education and primary organizer of the event. "We spent a lot of time focusing on delegates' individual needs, and I think that's one of the reasons the Institute was so well received by those who attended."

Even though the United States has 126 medical schools and Canada has only 16, Canada is recognized as being the North American leader in CME research. "We were honored to be asked to host the Institute," Sargeant said. "Dalhousie is regarded as a top-notch CME research institution, and that's something about which the entire Dal community should be proud."

Endowment Council Supports Research Activities

By Jan Z. Temple, Ph.D., Chairman

The Endowment Council has as its primary task to advance CME research for the benefit of the Society. Tasks include developing a vision for Society research efforts, identifying funding priorities, expanding endowment resources, and developing leadership in research for the organization. The following information is a brief update of activities in 2002-2003.

Endowment Council's Manning Awards are in progress with one project in the final stages and a new one under way.

The Council reviewed numerous small grants and currently has funded the following two initiatives:

- Stephanie Giberson, M.C.E. (University of Manitoba) for a project titled "Facilitating Physician Learning Community Development: A Pilot Project Using Internet Protocol Videoconferencing"
- Joan Sargeant, M.Ed. (Dalhousie University) for a proposal titled "Physicians' Attitudes toward Participating in Accredited CME Programs on the Internet"

A registration fee waiver was awarded to a new CME researcher, Laurie Clayton (University of Rochester), to attend the 2003 Summer Research Institute in June based on a strong proposal submitted to the Council.

The Council welcomes Michael Fordis, M.D. (Office of Continuing Medical Education, Baylor College of Medicine) and Harold Kessler, M.D. (Associate Dean, Post-Graduate Medical Education, Rush Medical College) as new members. Their backgrounds in securing federal grants and insight into development will be most beneficial as the Council reassesses its vision and direction.

At the 2003 Spring meeting, Jocelyn Lockyer, Ph.D., M.H.A. (University of Calgary) was announced as the chair-elect for the Endowment Council. Her established reputation in CME research will serve the Council well.

A Development Retreat is scheduled for November 6, 2003 to focus on strategic planning for the Council, to revisit the Council's vision, to identify barriers and issues facing CME research, and to address the need for and direction of a development initiative for the Council.

News from the American Medical Association

By Dennis K. Wentz, M.D.

As a matter of information but also disclosure to the readers of *Intercom*, I need to acknowledge that this will be my last regular contribution to *Intercom* on American Medical Association (AMA) matters, as I will be retiring from the AMA on December 1, 2003. Thus, be warned: this column will be largely reflective.

When I recently told the AMA's Council on Medical Education about my decision, I was once again reminded of the Council's historic and active role in medical education in the United States for 100 years (actually since 1847 but under another name). There is no other official body that I know of that considers all three phases of medical education on a *regular* basis, and has immediate and important input into all three, with the ability to cause change. The participation of external groups at Council meetings speaks to this. At the September 2003 General Session of the Council were Nancy Davis, Ph.D., SACME's President, the leadership of the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the Accreditation Council for Continuing Medical Education, the Alliance for Continuing Medical Education, the American Board of Medical Specialties, the Council of Medical Specialty Societies, and representatives from various specialty societies. In addition, there were representatives of medical students, residents, and fellows, and of course from the AMA Board of Trustees. The Board looks to the Council for advice on all medical education issues.

SACME members will be interested to learn that one of the two Board members attending all Council sessions is Nancy Nielson, M.D., Ph.D., the Speaker of AMA's House of Delegates. Dr. Nielson is well acquainted and very involved with the issues of medical education and academic medicine, since she is Associate Dean for Academic Affairs at SUNY Buffalo School of Medicine. The various sessions of the Council provide an unparalleled and recurring opportunity for dialogue, better understanding of the issues confronting each of the three phases of medical education, and actions to resolve them. I will miss keeping the issues in continuing medical education and continuing professional development before the Council.

The Council has complete responsibility for the AMA PRA program and credit system. At the June and September 2003 meetings, new rules for granting CME credit were approved that are probably of interest to medical school faculty. Newly approved are rules for AMA PRA credit for physicians who review manuscripts to be published in peer-reviewed national journals indexed in *Index Medicus*. The Council acted on recommendations of a blue-ribbon panel of editors of several of the most prestigious medical journals in our country, for example, the *Journal of the American Medical Association* and the *New England Journal of Medicine*. Working through an accredited provider, the editor will oversee a new process to arrange such credit – 3 AMA PRA credits are allowed per review, with a maximum of five articles per year. *Intercom* readers are already familiar with the Council's June 2003 decision allowing credit for active participation in test item-writing activities. Your faculty who are engaged in item-writing committees for national testing and specialty organizations, for example, the National Board of Medical Examiners, ABMS member specialty boards, and many medical specialty societies, may now receive AMA PRA credit for participation on these question-writing teams. Examples of the latter are the MKSAP program from the American College of Physicians, SESAP from the American College of Surgeons, the American College of Obstetrics and Gynecology PROLOG program, and many others.

I mention these not only because they are new, but also because they demonstrate once again the overall direction of the AMA PRA credit program over the past eight years. Step by step, we have moved to recognize learning and empower physicians for what they really do in their daily work. Although reading of authoritative medical journals became eligible for credit for individual physicians in 1997, a "full court press" started in 2000 when several other individual activities of physicians that involve active learning were made eligible for AMA PRA credit. Thus, being a first or second author in an article published in an indexed peer-reviewed journal, or author

of a published abstract of a scientific poster could lead to PRA credit. In all of these, there is documentation of an outcome. Teaching peers in CME activities certified for AMA PRA credit, or obtaining an advanced academic degree in a health-related field, or becoming board certified and/or maintaining board certification are also recognized for category 1 PRA credit.

In 2004, the Council will make some further crucial decisions about credit. SACME members are participating in pilot projects examining physician learning from interactive Internet-searching activities and in learning derived from active participation by physicians in quality improvement and outcomes assessment. The direction should be clear: the AMA PRA program is trying to reflect what physicians do in their daily work and to better recognize those components that represent learning. In 1988 a former SACME president, Phil Manning, M.D., wrote of a third phase of CME he called "instantaneous CME". Today, the concept is very close indeed: "just-in-time" or "just-for-you" learning is demonstrably valuable; appropriate recognition of it must be a high priority.

In looking back, I am embarrassed at our previous AMA attempts to call attention to the importance of self-directed and self-initiated learning. In 1990 we called for at least 50% of reported education to be in AMA PRA Category 2 activities. The opposition from practicing doctors, in the form of many resolutions to the House of Delegates, was formidable. Thus, in 1991 we decided instead to offer a new voluntary AMA PRA certificate "With Commendation for Self-Directed Learning" to physicians providing documentation of such activities. However, only a tiny percentage of physicians reported the documentation required. However, all of them believed they should receive the new certificate. Not surprisingly, the program was quietly ended –we received a very clear message that what physicians want is documented PRA category 1 credit.

There are those who say the credit system in the United States is permanently broken and cannot be fixed. In my view, practicing doctors just do not buy that, neither here in the U.S. or abroad. It provides a unique opportunity for those of us in CME and CPD. Our contribution at the AMA is to evolve the current credit system to more and more reflect and recognize individual learning by doctors. If you have specific ideas, please let either AMA staff or the Council on Medical Education know. Undoubtedly, the discussions and recommendations that will come out of the new Conjoint Committee on CME organized by efforts of the Council of Medical Specialty Societies will also be of great help.

Writing this column for *Intercom* has been very special for me, and I want to thank the Editor and the Society for the opportunity. There is so much going on in continuing professional development and continuing medical education that medical schools must take charge of and be the leaders, and SACME is the vehicle to make it happen. I am pleased that SACME now has official observer status in the AMA House of Delegates, and hope that not only the officers but also individual members will show up and participate in these meetings, especially the open sessions of the Section of Medical Schools and the Council on Medical Education. I promise to be observing from the sidelines and plan to continue to work in our field, but from a new base in Beaver Creek, Colorado. I am also going to write a history of CME in the U.S., and will be grateful for any tips and hints. But right now, I am looking forward to doing a little skiing in the Rockies! *Auf Wiedersehen*.

SACME Membership Statistics

The Society's Executive Secretariat is currently processing membership renewals for the 2003-2004 year. The following applications/renewals have been received.

8 Continuing Members
21 Emeritus Members
7 Honorary Members
156 Voting Members

Thus, the total 2003-2004 roster includes 192 members as of October 8, 2003. Thirty-eight membership renewals are still outstanding. The Secretariat urges all members who have not yet sent in dues payment for 2003-2004 to do so as soon as possible. Dues payment can be made using a credit card on the web site, http://sacme.org/dues_payment.htm.

For any questions regarding membership, contact the Executive Secretariat by phone at (205) 978-7990 or email sacme@primemanagement.net.

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:

Kathryn Andolsek, **M.D., M.P.H.,** Medical Director, Duke Office of CME, Durham, North Carolina

Renee E. Bowen, **R.N., J.D.,** Meharry Medical College School of Medicine, Office of Lifelong Learning, Nashville, Tennessee

Jeffrey C. Brandon, M.D., Associate Dean of Continuing and Graduate Medical Education, University of South Alabama, Mobile, Alabama

Laurie A. Clayton, Assistant Director, Continuing Professional Education, University of Rochester School of Medicine & Dentistry, Rochester, New York

Paul Dallas, **M.D.,** Director of Continuing Medical Education, Carilion Health System, Roanoke, Virginia

William J. Davis, **D.D.S., M.S.,** Director, Continuing Medical Education, Medical College of Ohio, Toledo, Ohio

Anita Dytuco, **CMP,** Program Manager, St. Louis University School of Medicine, Saint Louis, Missouri

Tom Elmslie, **M.D.,** CEO, The Foundation for Medical Practice Education, Ottawa, Ontario, Canada

Melinda Epperson, **M.Ed., CMP,** Interim Director, Center for Continuing Education, Tulane University Health Sciences Center, New Orleans, Louisiana

Leslie A. Ingraham, **M.S.,** University of New England, CME Department – College of Medicine, Biddeford, Maine

Kathy J. Johnston, Director, Continuing Medical Education, New York Medical College, Valhalla, New York

Gabrielle Kane, **M.B., M.Ed., FRCPC,** Director of Education, Canadian Association of Radiation Oncologists, University of Toronto, Department of Radiation Oncology, Toronto, Ontario, Canada

Celia J. Maxwell, **M.D.,** Director, Continuing Medical Education, Howard University College of Medicine, Washington, D.C.

Martha A. Medrano, **M.D.,** Assistant Dean for CME, University of Texas Health Science Center, San Antonio, Texas

Margie J. Miller, M.S., CPP, Associate Director for CME, University of Oklahoma, Oklahoma City, Oklahoma

Thomas E. Norris, **M.D.,** Associate Dean, University of Washington School of Medicine, Seattle, Washington

Curtis Olson, **Ph.D.,** Head, Research and Development, University of Wisconsin Medical School, Madison, Wisconsin

Floyd Pennington, **Ph.D.,** Associate Director, CME, University of Florida College of Medicine, Gainesville, Florida

Allison Rentfro, **M.P.A.,** Director, Continuing Medical Education, University of Missouri - Columbia, Columbia, Missouri

Judith G. Ribble, **Ph.D.,** Director, CME, Medscape, Santa Fe, New Mexico

Rial D. Rolfe, **Ph.D., M.B.A.,** Associate Dean for Faculty Affairs and Development, Texas Tech University Health Sciences Center, Lubbock, Texas

Michael D. Rosengarten, **M.D., FRCP,** Director and Associate Dean, CME, McGill University Faculty of Medicine, Montreal, Quebec, Canada

Doug Sinclair, **M.D., CCFP, FRCPC,** Associate Dean, CME, Dalhousie University, Faculty of Medicine, Halifax, Nova Scotia, Canada

Laurie E. Snyder, Manager, Accreditation and Educational Development, University of California, San Francisco School of Medicine, San Francisco, California

Jatinder Takhar, **M.D., FRCP,** Associate Dean Continuing Medical Education, University of Western Ontario, London, Ontario, Canada

Julie L. White, **M.S.,** Administrative Director, Continuing Medical Education, Boston University School of Medicine, Boston, Massachusetts

L. James Willmore, **M.D.,** Associate Dean, St. Louis University School of Medicine, Saint Louis, Missouri

Tracey W. Wolfe, **M.H.A.,** Administrative Director, Academic Affairs, Geisinger Health System, Danville, Pennsylvania

Suzanne Ziemnik, **M.Ed.,** Director, Division of Continuing Medical Education, American Academy of Pediatrics, Elk Grove Village, Illinois

Susan Zollo, **M.A.,** Director, CME Division, University of Iowa, Carver College of Medicine, Iowa City, Iowa

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Newsletter of the Society for Academic
Continuing Medical Education
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UPCOMING EVENTS

October 25-29, 2003
CME Leadership in the 21st Century
Durham, North Carolina
Contact: Joseph S. Green, Ph.D. (919) 684-6878

November 7-8, 2003
Association for Hospital Medical Education Fall
Educational Institute
Washington, D.C.
Contact: www.ahme.org

November 7-10, 2003
SACME Fall Meeting
Association of American Medical Colleges
Washington, D.C.
Contact: Jim Ranieri (205) 978-7990

December 12-13, 2003
Understanding ACCME Accreditation
Chicago, Illinois
Contact: Becky Flanigan (312) 464-2500

January 21-24, 2004
2004 Alliance for CME Annual Conference
Atlanta, Georgia
Web site: http://www.acme-assn.org

May 15-18, 2004
CME Congress 2004
Toronto, Canada
Contact: Conference Secretariat (416) 978-2719

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

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