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THE SOCIETY FOR ACADEMIC CONTINUING MEDICAL EDUCATION

Quality Improvement and CMS: The Role for CME

By Kenneth S. Fink MD MGA MPH
Chief Medical Officer
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Since publication of the Institute of Medicine's (IOM) Crossing the Quality Chasm report, health care has shifted into a new paradigm of quality improvement and patient safety. The IOM defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[a] Quality is important because it increases benefit and decreases harm, reduces variation, and improves value and health outcomes. Translating into practice new knowledge of effective interventions is important, and continuing medical education (CME) has an opportunity to help improve value and health outcomes as part of the new paradigm.

In a simplistic model, CME increases knowledge which leads to behavior or practice change that results in improved health outcomes. For this to hold true, the content of the CME would need to be evidence-based and without bias, related to the participant's scope of practice, and provide new knowledge. In addition, the CME intervention would need to be effective for transferring the new knowledge, and the system or organization in which the health care is delivered would need to enable the application of the new knowledge into clinical practice. Evaluations of CME have shown that its overall effectiveness for changing practice is poor. Didactics and print materials were found not to be effective but were the predominate CME modality;[b] however, interactive sessions were found to be effective.[c] Evidence also demonstrates that intervening at the systems level, such as through health information technology, can improve health outcomes.[d] Traditional CME has typically focused on communicating clinical information, and perhaps expanding CME to include education on health care delivery would have an additive or synergistic effect for improving outcomes.

The attention to quality improvement has given rise to the development of quality measures. Whereas CME tends to reflect input, quality measures tend to reflect output. In effect, CME is an intermediate measure with quality being an outcomes measure. Given the limitations to the effectiveness of CME and its questionable validity as a measure, state licensing agencies' and specialty societies' changing their requirements from completing a number of hours of CME to obtaining a minimum score on a group of quality measures is not inconceivable. More likely a hybrid policy could initially develop in which required CME is waived if a specified level of quality is achieved. However, a quality measure-based system requires valid quality measures, a reliable data source, and a fair methodology incorporating appropriate adjustments. Quality measures are being used in numerous fashions

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including confidential report cards, public reporting, and pay for performance. CME can play a role in improving quality by providing education on the clinical content related to an aspect of quality care as well as on the implementation of systems to improve the delivery of quality care.

The Centers for Medicare and Medicaid Services (CMS) is exploring using quality measures in pay for reporting and pay for performance. Rising health care costs drive a focus on value, and the current payment structure rewards quantity rather than quality of care. The sustainable growth rate (SGR), as legislated by Congress, is used to determine the physician fee schedule update, which is expected to be a 5% reduction for 2007. Many believe that the SGR is unsustainable and are calling for payment reform, and any reform is likely to align payment with quality. CMS's Physician Voluntary Reporting Program (PVRP) is the first step in this direction for physician services. Hospital pay for reporting is ongoing.

PVRP utilizes the administrative claims mechanism and involves the submission of G-codes or CPT category 2 codes to reflect the provision of care related to a quality measure. Alternatively, those with an electronic health record can contact their state Quality Improvement Organization and, if their system is compatible, upload the clinical data to a central data warehouse and not need to submit the additional information on claims. Providers do not need to register to submit data for PVRP, but those who do sign up will receive confidential reports at the tax identification, mostly the practice, level. Issues such as risk adjustment, use of process or outcomes measures, and attribution are being considered. Additional information about PVRP can be found at www.cms.gov/pvrp. Note that any change to physician payment such as pay for reporting requires Congressional action.

Quality improvement and pay for performance are becoming commonplace if not pillars of our evolving health care system. Within this system, effectively and efficiently translating knowledge into practice becomes increasingly important. CME has an opportunity, and perhaps a responsibility, to evolve accordingly and help providers improve the health outcomes of their patients.

Editors Note: This is a summary of a presentation given by Dr. Fink at the Fall SACME Meeting in Seattle. The slides from that presentation are available on the SACME Web Site.

(Endnotes)

a Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press; 2001.

b Bloom BS. Int J Technol Assess Health Care. 2005 Summer;21:380-5.

c Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P, Taylor-Vaisey A. JAMA. 1999;282:867-74.

d Chaudhry B, Wang J, Wu S, et al. Ann Intern Med. 2006;144:742-52.

From the President

By Michael Fordis, MD
President, SACME

Lost in Translation: Tales of the Invisible Plan

Although it was made in 1933, science fiction aficionados will undoubtedly recall scenes from the old Claude Raines movie based on H.G. Wells' book, *The Invisible Man*. Memorable in the film was the way in which Dr. Jack Griffin became visible to those around him only when wrapped with bandages, dark glasses, clothes, coat, gloves, and hat.

In many respects, effective use of Continuing Medical Education (CME) might be described as "*The Invisible Plan*" in one of the largest NIH initiatives to come down the pike in several years. In October of 2006, the National Institutes of Health announced 12 awards under a new cross-institute initiative entitled the Clinical and Translational Science Awards (CTSA) program. This major initiative promises to provide new treatments more efficiently and quickly to patients. Current plans call for increasing CTSA funding incrementally from about $100 million in 2006 to roughly $500 million supporting about 60 CTSAs in 2012.[1]

Among key elements of the CTSA program are activities that focus on enhancing capabilities in the areas of novel clinical and translational methodologies; bioinformatics; research design, biostatistics, and clinical research ethics; regulatory knowledge and support; research education, training, and career development; and community engagement. Community engagement does include, among the initiatives to encourage recruitment of research participants and outreach to community-based organizations, the focus of our interests—provider education and outreach.[2] For those of us who are integrally involved in CME activities at our respective institutions, the use of CME programming would appear to be a logical and natural way in which to engage community-based clinicians in the translation of scientific advances to applications in their offices and local hospitals.

However, the translation of scientific advances to office- and hospital-based applications is nearly invisible in the CTSA narratives submitted by 11 of the 12 projects funded in the first round of awards (one grantee did not provide a narrative on the website).[3] In few of the 11 posted descriptions did an institution's CME operation figure prominently in the community engagement proposals. Three made no mention of "CME" or "Continuing Medical Education", while in others it is visible only when it is "wrapped with credit" that can be provided to participants for ongoing learning relevant to education in research methodologies, ethics, regulatory compliance, research safety and other related issues. This is not to diminish the contributions that CME can make through the research courses that can be organized and the credit incentive that can be awarded; but this invisibility of CME as a fundamental component of outreach efforts represents a major untapped opportunity for CTSAs. The broad-based intra-institutional collaborations that must be assembled to undertake CTSA proposal development offer rare teachable moments where CME leaders, educators, and administrators within these institutions can provide assistance in taking new discoveries into their communities using the tools already at their disposal. It offers opportunities to engage the research community in clinical translation in the community of practice.

Most CME providers are not currently engaged in research, the language is foreign, and the culture differs from that familiar to educators. All of these can represent barriers to participation, leaving providers isolated from their academic research colleagues. This is perhaps not too dissimilar from the protagonists in another movie, *Lost in Translation*, where Bill Murray as an aging movie star with fewer roles to play and Scarlett Johansson is a dispirited newlywed abandoned by her husband and they find themselves dislocated in

a foreign land, disoriented by the culture and unable to decode the language. In the movie, the protagonists reach for each other and discover commonality. The CTSAs offer a similar opportunity for providers to discover shared interests with the research community, drawing upon decades of effective interactions with clinicians in the community. CME courses and other interventions including performance improvement and point of care decision support hold great potential as vehicles for translating change into practice. Moreover, the emerging emphasis on performance change within CME should offer much to a beleaguered Principal Investigator assembling the proposal. These are times to contribute to your institution's efforts in these important NIH initiatives. Those who remain silent or invisible may indeed become lost in translation.

1. Questions and answers about the NIH Clinical and Translational Science Award (CSTA) Consortium October 3, 2006; <http://www.ncrr.nih.gov/clinical-discipline/CTSA_MediaQsandAs_10-03-06.pdf>. Accessed January 29, 2007.
2. NIH Clinical and Translational Science Awards (CTSA): Status Sheet--January 2007. January 17, 2007; <http://www.ncrr.nih.gov/CTSA_Status-Sheet_01-17-2007.pdf >.
3. CSTA Awardees. *Clinical Trials Networks Best Practices: NIH Roadmap* [November 20, 2006; <https://www.ctnbestpractices.org/networks/nih-ctsa-awardees/#ctsa>. Accessed January 30, 2007.

Fall 2006 Meeting

By Nancy Davis, PhD, Program Chair

Seattle was a new venue for the AAMC meeting and SACME took advantage of a unique setting for a unique program. Everyone agreed the lovely amphitheater was a definite plus. Our time is short at the AAMC so we have to pack a lot into a shorter program. The opening session allowed for a comparison of the several initiatives to reform CME. Dave Davis, MD, gave his perspective from his experiences as the 2006 Petersdorf Scholar in Residence at AAMC. Bruce Spivey, MD, presented an update of the work of the Conjoint Committee, a coalition of CME stakeholders. Barbara Schneidman, MD gave an overview

of the work of AMA's new Initiative to Transform Medical Education (ITME) which includes CME in the continuum of medical education. Representing the Canadian revalidation initiative was Craig Campbell, MD. Respondents included Sue Ann Capizzi, MBA, AMA; Nancy Davis, PhD, AAFP; and Murray Kopelow, MD, ACCME. Consensus was that there is much overlap among these reform initiatives. SACME members resonated with the plans for reform and provided constructive discussion to inform the work of the various groups.

One of the more provocative sessions was led by Norman Kahn, MD, AAFP who moderated a discussion with Kenneth Fink, MD, CMS. This message was around the role of CME in performance improvement and pay for performance related to Medicare and Medicaid

compensation. Participant discussion focused more on issues around pay for performance than CME, but certainly the message around the need for CME to evolve around this issue was clear.

Finally, LuAnne Thorndyke, MD, Penn State University moderated a discussion around alternatives to CME funding. Panel members included Stephen Willis, MD, North Carolina AHEC; R. Van Harrison, University of Michigan; and Michael Saxton, Pfizer. This lively discussion focused on changing trends in pharmaceutical funding and the need for academic CME to explore alternative funding sources. There was optimism from Mike Saxton who presented an overview of the movement within pharmaceutical companies to hire educators and have a better sense of sound education and evaluation principles.

The Research focus at the Fall meeting was presented by Craig Campbell, MD, Chair, SACME Research Committee and Gabrielle Kane, MD, PhD, Chair, SACME Research Endowment Council, who asked the group to brainstorm around the future of SACME research including agenda, nurturing new researchers, dissemination of CME research and how best to foster CME research universally.

Several presentations from the Fall 2006 program are available at the website, www.sacme.org along with photographs from the meeting. Those of you who were there will enjoy the memories and those who weren't, won't want to miss next year!

News from the American Medical Association

By Alejandro Aparicio, MD, FACP

The 17th Annual Conference of the National Task Force on CME Provider/Industry Collaboration took place October 16-18, 2006 in Baltimore. This past year's conference had the largest attendance to date. The Keynote Address, delivered by CAPT David Rutstein, MD, Office of Public Health and Science, U.S. Department of Health and Human Services and Chief Medical Officer, United States Public Health Service, was titled: "Where Would We Be Without CME?" He related his experiences while serving in Micronesia, where he did not have the CME infrastructure that we have available to us in our daily professional lives. He had to come to the U.S. to attend CME activities and felt fortunate when he was able to do it once a year. The CME activities were all the more important to him since he was one of only a few physicians available, and at times the only one, and expected to deal with any situation that came up. I am sure that I was not the only physician in the audience that appreciated the very personal and powerful account of his work while being reminded of the richness of our educational environment, which we should not take for granted. In November, at the semi-annual policy-making meeting of the AMA, Dr. Rutstein was awarded the American Medical Association (AMA) Medal of Valor for his leadership in public health following the devastating Spring 2005 earthquake on the Indonesian

Island of Nias. At that time, AMA President William G. Plested, MD, remarked: "Dr. David C. Rutstein demonstrated extreme courage during the aftermath of the Indonesian earthquake, treating patients, helping to contain disease and properly evaluate the environment to promote public health. His work saved lives and prevented many from becoming ill. We are pleased to honor Dr. Rutstein with the AMA Medal of Valor for his service in public health."

Other plenary sessions included the "Update on Federal Regulations," "Capitol Hill's Interest in CME," "Issues Arising from the Implementation of the ACCME's 2004 Standards for Commercial Support: Standards to Ensure Independence" which also included a discussion of the 2006 ACCME Revised Model and Updated Accreditation Criteria, and an interactive session where case studies submitted by the audience were examined to determine compliance with different guidelines and regulations. There were also multiple breakout sessions including communities of practice breakouts. The credit for the success of the conference goes to the planning committee chaired by Greg P. Thomas, PA, MPH and Pamela Mason, Conference Co-Chair, and the rest of the planning committee and the faculty. SACME was very well represented in both of those groups as well as in the audience.

The planning committee is already hard at work developing the program for this year's conference. The 18th Annual Conference of the National Task Force on CME Provider/Industry Collaboration will take place October 17-19, 2007, at the Hyatt Regency Crystal City, in Arlington Virginia. If you have any suggestions regarding the format or topics, please do not hesitate to contact me or Kevin Heffernan (kevin.heffernan@ama-assn.org).

On a different topic, the AMA Division of Continuing Physician Professional Development (CPPD) has, for the past three years, held regional meetings to disseminate information about the PRA credit system, particularly the evolution that has taken place with the new formats of learning that we share with the American Academy of Family Physicians and the shift from hours to credit in the CME terminology. Our hope was to reach persons involved in CME that do not always have the opportunity to attend national meetings and may not have other opportunities for interaction with colleagues This year, our plan is to experiment with a different format. We will be holding webinars that will probably concentrate on two topics: one will be an update on the PRA credit system and the other will discuss the Performance Improvement (PI) CME format. There will be more than one iteration of each with each PI session targeting a different type of provider.

We hope that all of you are receiving our CPPD report. We publish it three times a year. If you want to subscribe or if you have any comments or suggestions please contact Mary Kelly, managing editor, mary.kelly@ama-assn.org or Jeanette Harmon, editor, jeanette.harmon@ama-assn.org. You can also access it on line at www.ama-assn.org/go/cmecppd. The 2007 winter issue has been published and the lead article is authored by Dave Davis, MD, and titled "That's not *exactly* what I said" I know you will enjoy it as much as I did.

By the time this issue is published, we'll be well into the new year, but it is being written at the beginning of January, so, in the spirit of the season, all of us at the Division of CPPD wish all of you and your loved ones a safe, prosperous, healthy and happy 2007.

We hope to see you at Copper Mountain.

CACHE not CASH!- The Canadian Association of Continuing Health Education

By Doug Sinclair, MD
CACHE representative to Congress 2008 planning committee
SACME board member

CACHE is a new organization in the CME/CPD world. The inaugural meeting was held in Ottawa, Ontario in 2001, under the able co- chairmanship of Dr Bernard Marlow, and Dr. Gary Sibbald. Since that time, a meeting has been held each year, bringing together Continuing Health Educators from universities, medical associations, industry, and CE companies from across Canada.

At the annual meeting in St. John's Newfoundland this past September, a board of directors was nominated and ratified by the new organization, with the University of Toronto CME office supplying logistic support. Over 200 delegates attended the meeting in St. John's with representatives from a diverse group of continuing education providers.

The mission of CACHE is to provide a Canadian forum for CHE providers and customers to:

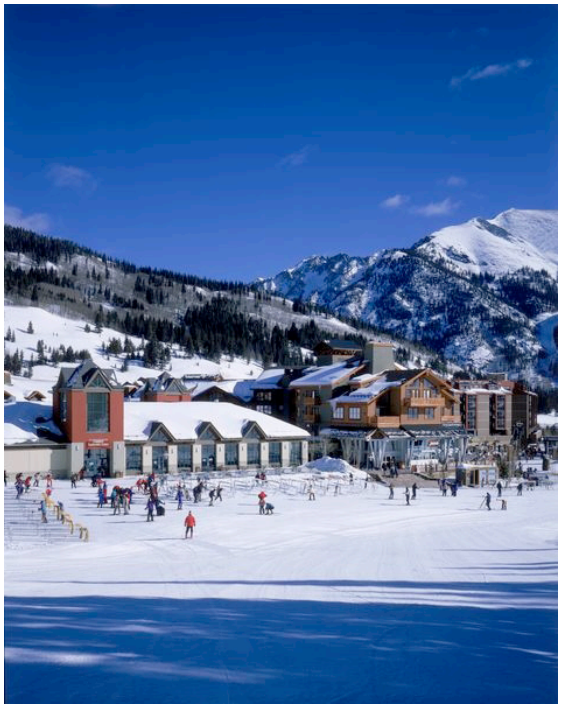
- share CHE knowledge and resources
- contribute to the existing body of CHE research by promoting and supporting original CHE research
- encourage and support CHE initiatives which foster collaboration and integration between CHE providers and sponsors
- endorse ethical CHE which seeks to improve overall health care outcomes

As well as developing an annual meeting, CACHE also has a web site [www.cachecanada.org] and a CE directory. The next meeting will be held in Quebec City from October 13-15, 2007. CACHE is also pleased to be a planning partner for Congress 2008 .

For assistance with the SACME Listerve, such as receiving the messages in alternate formats, please contact the Executive Secretariat at sacme@primemanagement.net or the Listserve Administrator at dpieper@med.wayne.edu.

Spring 2007 Meeting Takes High Altitude View of the Future of CME

By Nancy Davis, PhD, Program Chair



CME as a Bridge to Quality is the opening session at **the SACME Spring meeting in Copper Mountain, Colorado, March 29-April 1**. The session will feature ACCME's new criteria for accreditation and suggestions for implementation. The revalidation process in Canada will be featured as well. Participants from both sides of the border will gain insight into the value of CME for improving the quality of patient care. Other sessions will provide discussion around new approaches to CME including evaluation, innovations in outcomes measures, and integrating quality improvement and CME. The Program Committee has created a balance between new learning and sharing of best practices.

The cornerstone of the Spring meeting is always Research in CME (RICME). Here our members have an opportunity to showcase their research and get feedback from fellow participants who range from internationally recognized educational researchers to pragmatic practitioners. Members have until **February 23** to submit proposals for the two RICME sessions.

We're fortunate to hold our meeting in the backyard of our featured guest speaker, David Price, MD. Dr. Price is Director of Physician Education for Kaiser Permanente of Colorado, and holds national guideline and education positions with the Kaiser Permanente Care Management Institute in Oakland, CA. An Associate Professor of Family Medicine at the University of Colorado Health Sciences Center, Dr Price was awarded the Colorado Family Practice Teacher of the Year Award in 1991. Additionally, he serves as Chair-Elect of the American Board of Family Medicine. Dr. Price's presentation, "CME, Quality Improvement and Organizational Change", is based on a recent paper he published, available at the SACME website for reading prior to the meeting.

The Committee meetings will be spread out more throughout the week. So check your favorites and plan to attend. You only get out what you put into a great organization like SACME. Plan to get involved!

But the Spring meeting will not be *all* scholarly activity. There will be time to hit the slopes of one of the finest ski resorts in Colorado. Additional activities include dog sledding, snowmobile touring, snowshoeing, tubing, and don't forget shopping and celebrity-watching at nearby Vail. Visit the Copper Mountain site at www.coppercolorado.com.

Genevieve Napier, Bris Villanueva and their team at Northwestern University's Feinberg School of Medicine Office of CME will host the meeting and have done a great job with the logistics. For more information contact them at b-villanueva@northwestern.org or 312-503-8533.

See the SACME website, www.sacme.org, for full information, meeting registration and hotel registration materials. Also, check the site for updated reading and other materials prior to the meeting.

Continuing Education
Faculty of Medicine - University of Toronto

The Society for Academic Continuing Medical Education

The Society for Academic Continuing Medical Education (SACME)

Summer Institute for CME Research 2007

Saturday June 17 – Wednesday June 20, 2007

Continuing Education, Faculty of Medicine
University of Toronto
Ontario, Canada

The **SACME Research Institute** is a short, intensive course on research methods in Continuing Medical Education. It enables participants to select learning activities of most value to them, at their particular level of research skill and knowledge. The program will be tailored to offer:

- Presentations on the core principles and processes of educational research
- Mini Workshops to explore topics in depth and to practice research skills
- Individual consultation with experienced researchers about participants' proposals or studies
- An opportunity for participants to develop their own research proposals and studies

Registration for the Institute will request each participant identify and submit a research idea, proposal or issue that they would like to develop or explore during the institute. These questions will need to be received on or before May 24, 2007 to enable planning of breakout groups, identification of potential mentors etc.

We will create and distribute a reflective tool that can be used by individuals who will participate in the research institute to guide their reflection, critical thinking and the translation of the key messages from the educational activities within their evolving proposals.

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

For more information, please visit the SACME web site http://sacme.org shortly.

If you have questions, please contact the Institute organizers:

- Craig Campbell MD FRCPC
  email ccampbell@rcpsc.edu
- Ivan Silver MD MEd FRCPC
  email ivan.silver@utoronto.ca
- Gabrielle Kane MB EdD FRCPC
  email Gabrielle.Kane@rmp.uhn.on.ca

For up-to-date information on SACME activities visit us often at **http://www.sacme.org**

Offers of Speakers for RSC Sessions by MECCs

We recently had a lively discussion on the SACME Listserv regarding a relatively new phenomenon that many of us had begun to experience in our institutions. Although there were a several variations on this theme the basic scenario is this: A medical education company phones, e-mails or sends a glossy brochure to the staff person in an academic department who is responsible for helping to fill grand rounds faculty slots.

The medical education company indicates that they are able to provide a speaker on a topic that may be of interest to physicians who attend grand rounds presentations. The education company offers to take care of travel arrangements, honorarium, and the cost of a meal associated with this presentation. They will provide several potential dates that the faculty member will be available and will forward, if requested, the faculty members CV and general information about the talk.

The Medical Education and Communication Company (MECC) states that the talk has already been approved for CME credit by them (or another accredited provider). They then request that your institution sponsor the activity, awarding CME credit.

The MECC faxes over a document that outlines everyone's responsibilities and deliverables for signature. The document indicates that your institution will be responsible for compliance with ACCME accreditation requirements and the MECC will provide the speaker and cover all related expenses (travel and honoraria).

This is often seen as a wonderful gift from the perspective of the departmental staff member. They fill a slot with an outside speaker (always a bonus), all expenses are paid (including a meal) and they really don't have to lift a finger. But, their headache, and yours, began when they contacted you about the "great deal" and forwarded the agreement for signature. The dilemma, as described on the Listserv discussion, is that the original source of the funding to cover the speaker honorarium and other expenses is a pharmaceutical company grant to the MECC.

As we know, when you incorporate a speaker into one of your grand rounds, you are required to have a signed Letter of Agreement with the commercial supporter. The problem we face is that the commercial supporter has already given the grant to the MECC and has been unwilling to sign an additional, separate Letter of Agreement with you for the funds related to pay for the expenses of this lecture.

In the course of the Listserv discussion several additional issues were raised regarding the advisability of entering into this type of relationship with an outside educational partner, the Letter of Agreement issue was a clear "show stopper."

In response to a direct request to the ACCME for clarification on this issue, Dr. Kopolow issued a formal letter, reinforcing our understanding that a Letter of Agreement between the supporter and provider was needed. However, he also indicated that the ACCME would consider the provider to be in compliance with SCS 3.4 if the provider had a copy of the original Letter of Agreement between the MECC and the commercial supporter as well as a detailed agreement between the MECC and the provider. According to some Listserv members, and a few other SACME members I've spoken to about this issue, the MECCs aren't generally willing to share the original Letter of Agreement and the academic providers find themselves back at square one.

The alternative solution that is occasionally proposed is to have the MECC certify the activity for CME credit, either using their own accreditation, or the accreditation of another institution that was part of the original educational grant proposal. But, if you consider every lecture in that series to be part of a single grand rounds

Mark Your Calendar!!
2007 Summer Research Institute
Mid June 2007
Toronto, Ontario
Contact: Craig Campbell, MD
ccampbell@rcpsc.edu

Regularly Scheduled Conference (RSC) activity, you will have to remove it from the RSC and it will become a separate CME activity that is certified by an outside entity. It was noted on the Listserv discussion that this creates its own problems, not the least of which is confusion on the part of the attendees.

The final part of the Listserv discussion was related to the problems this type of practice has for the oversight role of the academic CME Office. A number of people indicated that they do not allow other CME providers to sponsor activities at their institution or only do so as a co-sponsorship or in special circumstances approved by the CME Director. The issue seemed to be one of educational control of CME activities within an academic institution. If another provider is sponsoring a CME activity at your institution there is no way for you to have any control of the content, delivery, or compliance with ACCME accreditation requirements unless there is an institutional policy giving you that authority. However, in most institutions, there is the tacit assumption by attendees that the CME Office is responsible for all CME activities that take place in their institution.

While almost everyone who commented on the Listserv about this issue identified it as a problem there was also recognition that it might be difficult to completely control in the short term. Most offers of collaboration are made directly to the departmental RSC coordinators and bypass the CME Office. If they offer an attractive opportunity to bring in an outside speaker with all expenses paid, RSC coordinators could be highly motivated to make these deals work for them. It also puts the CME Office in the position of being the "bad guys."

As with many issues we've discussed on the SACME Listserv, there was no definitive solution or "golden bullet." However, the many comments were successful in sharing how many institutions have addressed the issue and we were also able to get some additional clarification on the issue from the ACCME. Thanks to all who participated.

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March 28-April 1, 2007
Copper Mountain, Colorado
Contact: Nancy Davis, ndavis@aafp.org

MedBiquitous Annual Conference 2007:
Common Goals, Common Solutions
April 16-18, 2007
Baltimore, Maryland
Visit the conference website for details http://www.medbiq.org/events/conferences/annual_conference/2007

2007 Summer Research Institute
June 17-20, 2007
Toronto, Ontario
Craig Campbell, MD ccampbell@rcpsc.edu

CME Congress 2008 and Spring SACME meeting
May 29-31, 2008
Sheraton Wall Centre
Vancouver, British Columbia Canada
Contact: Craig Campbell, ccampbell@rcpsc.edu