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INTERCOM

THE SOCIETY FOR ACADEMIC CONTINUING MEDICAL EDUCATION

Congress for CME, May 29 – 31, 2008
Vancouver, British Columbia

SACME is the lead organization for the Congresses on CME which are held every four years. Congresses are designed to bring CME researchers and leaders together to learn about innovations and cutting edge research and to exchange ideas that will further the field.

Five core themes have been identified for the Vancouver program: assessing competence, interprofessional education, educating physicians to work within systems of care, self-assessment and self-directed learning and global issues in CME. Each of these themes will be explored by a keynote speaker along with a discussant. Workshops, short presentations and posters will provide an opportunity to consider each theme more fully.

Keynote speakers include: John Gilbert, Principal and Professor Emeritus, College of Health Disciplines, University of British Columbia; Eric Holmboe, Senior Vice President for Quality Research and Academic Affairs at the American Board of Internal Medicine; Glenn Regehr, Richard and Elizabeth Curry Chair in Health Professions Education; Grace Tang, President, Hong Kong Academy of Medicine; and Charles Kilo, CEO, GreenField Health.

More than 600 delegates are expected to attend with participation from around the world and especially from SACME partner organizations: the Alliance for CME, Association for Hospital Medical Education, and from the Canadian Association for Continuing Health Education, and University of British Columbia (our host institution).

Register early to secure your spot in the program.

In This Issue

From the President: Hand-washing and the Macy Report

By Jocelyn Lockyer, PhD
President, SACME

Atul Gawande describes the efforts of both Semmelweis and Lister to introduce hand-washing.[1] From published accounts, it appears that Semmelweis' approach and personality hampered his ability to convince others. By contrast, Lister's clearer more persuasive and respectful plea for antisepsis in *Lancet* provided a more compelling rationale for hand-washing. As they say, the rest is history, although our institutional leaders still struggle to ensure that hands are washed consistently with every patient encounter.

Throughout the history of medicine, there are numerous examples of radical shifts in health care. Reconceptualization of hormone replacement therapy and H-pylori remind us that research can and must re-shape our beliefs and practices. As Malcolm Gladding suggests, we will get break-throughs when controversial new ideas gain sufficient champions and momentum to achieve a "tipping point".[2]

Recently, the Josiah Macy Foundation hosted a consensus conference, Continuing Education in the Health Professions: Improving Healthcare Through Lifelong Learning.[3] That report challenges our work in continuing education (CE). It criticizes the over-reliance on commercial support from pharmaceutical and medical device manufacturers, the frequent use of inadequate (and unproven) CE methods, funding sources and the way that providers and programs are accredited within each profession.

Not unlike the hand-washing story, there are objectors to the report. The use of commercial support is a predominant theme but others question the feasibility/practicality of the recommendations for CE financing and accreditation.

Opposition aside, the Macy report provides us with an opportunity to question what we are doing. Many would agree that the data from various systematic reviews and meta-analyses are compelling.[4,5] CE has not achieved the levels of performance that we have desired. While it is true that "one-off research studies" show that we can make improvements when we are sufficiently funded to carry out an intensive campaign, these resources are rarely available on a sustained basis. Physician performance frequently drops when our attention is diverted to other learning activities and systems do not exist to sustain changes. Without significant funding, the "optimal" methods of helping physicians learn cannot systematically be incorporated into our way of doing business. Even if we could gain continued resources for each disease campaign, this has to be a sub-optimal way of addressing the deficiencies identified by population health studies.

The Macy report also challenges our accreditation systems which have not embraced interprofessional collaboration, teamwork or improved systems. It criticizes our failure to help physicians use new IT to learn and care for patients. For too long, our focus has been on teaching (or hours of learning) but not helping physicians to learn on a continual basis each and every day. While quality improvement initiatives could help physicians learn and provide feedback about performance, they are rarely part of our repertoire.

In short, we have neglected high-quality study of CE and continued to carry out our work without questioning it much the same as the clinicians ignored Semmelweis' results, waiting for the evidence provided by Lister and Pasteur and the emergence of a sufficient group of adopters.

The momentum to re-shape CME is increasing. The Macy Report is one of many reports, research studies and media exposés, that question our ability to do what most of us believe we need to do—enhance the care that physicians provide. Indeed, SACME's mission is to promote the research, scholarship, evaluation and development of CME/CPD that helps to enhance the performance of physicians and other healthcare professionals practicing in the United States, Canada, and elsewhere for purposes of improving individual and population health. Similarly, our sister organization, the Alliance for CME's mission as a membership organization states that it provides professional development opportunities for CME professionals, advocates for CME and the profession, and strives to improve health care outcomes.

As CE providers, we will only achieve our vision if we critically evaluate our efforts, stop wringing our (clean) hands, and begin to re-shape what we do. It will be one step at a time to test new modalities and approaches. It will require all of us along with our colleagues in quality improvement, epidemiology, organizational psychology and other fields to figure out how we can truly help physicians.

Let us use the criticism to campaign for a better tomorrow. I challenge you to join hands with me to find the resources to do the job that needs to be done.

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SACME Fall 2007 Program: Translational Research and the Role of CME

By Nancy Davis, PhD
Program Chair

A record 88 participants attended the 2007 SACME Fall meeting held in conjunction with the AAMC annual meeting focused on translational research. The keynote session featured David Atkins, MD, MPH, Chief Medical Officer, Center for Outcomes and Evidence, Agency for Healthcare Research and Quality (AHRQ) and Steven Woolf, MD, MPH, Professor and Director of Research, Department of Family Medicine, Epidemiology and Community Health, Virginia Commonwealth University. Both encouraged academic CME providers to package continuing medical education in a way that emphasizes the best evidence in a way that leads to optimal patient care. Dr. Atkins described AHRQ's roles in funding health IT research, developing evidence base for best practices, and promoting collaboration and dissemination. He cited 2008 priorities in patient safety, ambulatory care, effective health care programs, medical expenditure panel surveys and other research and dissemination activities. AHRQ's comparative effectiveness reviews are excellent resources for CME needs assessment and content. He described the changes in the quality landscape including electronic health records (EHR); pay for performance (P4P) and quality transparency; complex patient care coordination; and personalized medicine. This changing environment

has implications for CME, Dr Atkins explained, with EHR creating the potential for real time education and information targeted at gaps in practice; P4P creating incentive for clinicians to seek solutions; complex patients requiring more targeted CME; and physicians needing to learn to tailor treatment decisions. Finally, Dr. Atkins challenged academic CME providers to move from a focus on "latest and greatest" to "safest, most proven and best value."

Dr. Woolf cited many studies that show the US in a health care crisis with high cost and relatively low quality of care. In the attempt to improve the quality of healthcare following the IOM reports, there has been a surge in translational research. Originally described as "bench to bedside", translational research now goes further to include "bedside to practice." Part of CME's responsibility is to package evidence in appealing ways to get the attention of physicians as well as the public.

Building on his Spring RICME presentation, Todd Dorman, MD, Associate Dean & Director of CME, Johns Hopkins University School of Medicine, presented the findings of AHRQ-supported evidence-based review of the effectiveness of CME. Results were reported in domains of knowledge, attitudes, skills, behavior, and clinical outcomes. For knowledge, skills, behavior, and clinical outcomes, studies showed that activities were more effective when they had multiple media formats, used multiple techniques and multiple exposures. There were not enough studies to be conclusive regarding skills. The report can be accessed at: www.ahrq.gov/clinic/tp/cmetp.htm

The RICME session included three presentations of studies in progress allowing researchers to receive feedback from participants. It was a very interactive session with researchers and participants all benefitting from the exchange.

Dave Davis, MD, Vice President, Continuing Health Care Education and Improvement; and Carol Aschenbrener, MD, Executive Vice President, AAMC shared their vision of AAMC's role in improving academic CME. Dave promised that SACME will have an active role and there will be more opportunities for collaboration with AAMC. He suggested some AAMC initiatives to meet these goals including better communication vehicles such as websites and email listservs, training in health services and educational research, promoting grant acquisition, databases, surveys (in fact, AAMC will now partner with SACME for the biennial survey), recognition of best practices and new models. Dave welcomes input from fellow SACME members. He concluded with this quote adapted from President John F. Kennedy's address to the General Assembly, UN, Sept 20, 1963, *"The value of this body's work is not dependent on the existence of crisis. (Health and health care) is a daily, weekly, monthly process--gradually changing opinions, eroding old barriers, quietly building new structures. And however undramatic its pursuit, that pursuit must continue."*

Another follow-up session from the Spring meeting was presented by Barbara Barnes, MD, Associate Dean, CME, University of Pittsburgh School of Medicine, regarding the academic health centers' response to ACCME Criteria for Accreditation. After background presentation of ACCME data showing medical school CME producing more on-line CME and fewer live courses, but regularly scheduled series still the staple of academic CME, Barbara posited that medical school CME is often decentralized with learners remote from the accredited institution. Formats are largely traditional and funding targeted to logistics and support of faculty. ACCME has given minimal guidance on criteria for assessing compliance with the new accreditation criteria and expectations for compliance across a provider's program. Interactive discussion followed regarding new programming to include performance improvement CME, focusing on skills-based and competency oriented activities and making the business case for a new type of academic CME.

Some pictures from the Fall meeting can be seen at http://www.sacme.org/index.cfm?&id=4016

Fall Research Workshop

SACME's annual research workshop was held immediately prior to the Fall meeting. The workshop was led by Tanya Horsley, PhD, Research Associate, Center for Learning in

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Improving Medicine And Patient Care Through The Development Of More Competent CME Leaders

By Philip A. Dombrowski, MBA
President and Chief Executive Officer, Annenberg Center for Health Sciences at Eisenhower

We are all struggling to find our way through the political, financial, professional, and organizational challenges now confronting the CME profession. Isn't it at times like this when people question if it's worth the trouble or worse, their own capabilities? Wouldn't it be a lot easier if a few super heroes or those with supernatural powers arrived to solve our problems for us? Where are the CME super heroes; do we even have CME super heroes?

Although neither super hero nor supernatural, the efforts of a small group of dedicated CME professionals (Nancy Davis, Phil Dombrowski, Harry Gallis, Joe Green, Marcia Jackson, Bob Kristofco, James Leist, Mark Schaffer, Maureen Doyle-Scharff, and Gordon West) may soon have some help to offer. Building on the success of the Duke leadership program (as many of the current steering group members were involved with that initiative) and with significant help from the CME community, this group has been working, for a little over a year, to better understand the leadership development needs of the CME profession. The small group's goal? To develop ways we can each improve our own leadership competencies so we can better guide and direct our departments and organizations and ultimately the profession as a whole. Funding for the initiative to date has been provided by the Annenberg Center for Health Sciences at Eisenhower and, in part, from the Annenberg Foundation.

Numerous planning and organizational meetings led to a Fall 2007 invitation-only conference of nearly 50 CME professionals under the banner *Transformational Leadership in Continuing Medical Education*. The goal for that meeting was to ask current CME leaders to help identify the gaps in knowledge, skills, or attitude between essential skills and current skills. Leaders were invited from all the major provider types and organizations essential to transforming CME. Included were representatives from medical schools, medical specialty societies, hospitals, state medical societies, and medical education communication companies. Representatives from the pharmaceutical industry were also involved since they are a major financial underwriter of CME.

Shared knowledge started with identifying current external environmental factors and evolved to identifying

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SACME Fall 2007 Program

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Practice, The Royal College of Physicians and Surgeons of Canada, and focused on the methodology and conduct of systematic reviews and meta-analyses. Following this introductory workshop, participants were invited to join a *Systematic Review – Community of Research Practice (CoRP)* and participate in further discussions and training activities throughout the year. Individual members of the Society who participate in the CoRP will be given the opportunity to work collaboratively with other colleagues to address relevant continuing medical education-related research topics (nominated externally or internally) that can be answered by systematic reviews. The CoRP will provide on-going training to members and establish a sustainable infrastructure to support the development and conduct of the systematic reviews through face-to-face meetings as well as continuous collaboration. SACME is interested in conducting systematic reviews to further CME research. The Research Committee, Research Endowment Council and Board are very supportive of such a project. For further information on CoRP or to get involved, contact Research Committee Chair, Craig Campbell. (There is also an article on CoRP in this issue of the *INTERCOM*)

the core competencies likely to affect the transformation of CME. Provider-specific small groups then identified and rank-ordered the specific competencies they felt were required to transform CME within their provider groups. Throughout the meeting, provider-specific small groups shared their findings with the larger group. Participants found this large group sharing especially informative. In most cases the core competencies were similar, but what was interesting was the rank ordering of the competencies and the rationale for the rank order. The small groups' last task was to identify those competencies where the greatest gap existed between the current practice and the ideal, identifying those gaps where educational interventions could resolve the discrepancy. The participants left the meeting enriched and informed; the planning committee felt the meeting had surpassed their high expectations.

The summaries from this meeting were shared with each participant, were discussed in depth by the steering committee, and served as the content for a three-hour intensive workshop at the January annual conference of the Alliance for CME Annual Meeting in Orlando, Florida. Intent on helping CME leaders identify their own important transformational projects, participants at this workshop received a list of questions adapted by Nancy Davis and Jim Leist from John Kotter's work on *Leading Change,* first published by the Harvard Business School Press (1996). Presenters demonstrated the application of the questions to examples of transformational projects while also offering participants an opportunity to complete the questions using a provider-specific case. Participants were then encouraged, when they returned to their offices, to use the form to identify their own transformational project and share that with the CME leadership steering group.

If the CME profession is to succeed in transforming itself, as it must, neither magic wand nor extraterrestrial super hero will be involved. Our success will come from each of us becoming engaged in transforming ourselves. This will lead to changes in our departments, our organizations, and then ultimately, for the entire profession. Each of us must be our own super hero.

Toward a SACME Community of Research Practice (CoRP)

By Tanya Horsley, PhD
Centre for Learning in Practice (CLIP),
The Royal College of Physicians and Surgeons, Ottawa, Canada

As my first submission to *INTERCOM*, I had high hopes of wowing fellow SACME members with a catchy title, a witty opening paragraph, or at the very least a nice accompanying photo in keeping with many of those who have submitted to the *INTERCOM* before me. You have seen the title (no rhymes), are reading my opening paragraph (no punchlines), and have noticed there is no photo (a good thing?); have I undoubtedly failed in my efforts? Not entirely. When finally putting pen to paper I realized that the value is in the product, not the packaging, and I hope this "product" sells itself to you.

In the Fall of 2007, through the vision of Dr. Craig Campbell, an idea of developing a Community of Research Practice (CoRP) around systematic reviews was born. The objective was to facilitate the generation of a community of SACME members interested in discussions, learning opportunities, and involvement in the production of high-quality, relevant, systematic reviews to advance the discipline of CME/CPD and inform best practice. Why all of this effort?

To many, the utility of a well-done, thorough, systematic review is undisputable.[1] Unlike traditional research

syntheses, systematic reviews make explicit attempts to limit bias by systematically identifying, appraising, and summarizing literature that may or may not statistically combine (meta-analysis) effects into one single summary estimate. Aside from the assembly and summary of studies, it is of particular value that systematic reviews identify consistencies or inconsistencies of findings that are interpreted within the context of "all" relevant evidence.

The task of preparing a systematic review however is not a trivial one. The 20th century has seen a proliferation of research into the development of explicit methods for systematic reviews and in doing so have identified two major challenges: (1) the quality of systematic reviews is often variable[2] and (2) systematic reviews of similar topics result in discordant findings ultimately jeopardizing the validity of conclusions.[3] While systematic reviews stake claim as the best source of evidence, in order for this to be upheld, it is crucial that they be well conducted and well reported.

The biomedical community has long since recognized the need for research syntheses, and although research within continuing medical education (CME) and professional development (CPD) is in its infancy comparatively, adopting these principles and promoting the training of systematic review producers and end-users is imperative to advance the discipline.

Thus, the objectives of the SACME CoRP are to:

- Establish, support, and sustain a network of individual members of the Society (scientists, medical researchers, medical educators, epidemiologists, physicians, etc.) who have a common interest in the discussion, development, production, and reporting of systematic reviews related to CME/CPD
- Produce systematic reviews that are relevant, of high quality, and maintained (up-to-date).
- Ensure that findings from systematic reviews completed by the CoRP are disseminated to a broader CPD/research community through publication, presentation, and open-access initiatives
- Provide opportunities for members to share their learning and experience to foster the development of authors of systematic reviews in CME/CPD

We are currently a group of 15 geographically dispersed individuals, informally bound to one another with a common interest in the production of systematic reviews related to CME/CPD, voluntarily engaged in sharing and learning from each other's expertise and jointly developing best practices. This approach of developing a network of multidisciplinary individuals to produce and disseminate systematic reviews is not a new phenomenon. Thus, many of the proposed CoRP principles are echoed by other organizations and include:

- Promoting enthusiasm in the process and methodologies of systematic reviews
- Striving for relevance of topics pursued by the Society
- Avoiding unnecessary scholarly duplication through efficient management, organization, and transparency of topics being conducted by members of the Society
- Ensuring reviews are maintained and up-to-date
- Striving for excellence in the production of reviews by ensuring that methods are appropriate and reporting is transparent and according to accepted and established standards.

"What's in it for me?"

All members can engage in learning opportunities provided through CLIP and discussions with other CoRP members. We have already completed an initial learning opportunity titled "An Introduction to Systematic Reviews" that was attended by 19 inaugural SACME members and we are facilitating another for late January titled "Searching for Evidence – The Reviewer Perspective". Although CLIP will facilitate the learning opportunities, the "topics", are driven in part by the discussions, suggestions, and gaps in knowledge and skills identified by the CoRP members.

There is an inherent "learning-on-the-run"[1] component, both through members' experiences in developing a systematic review and opportunities for discussing shared experiences. These learning opportunities can include (but are not limited to):Engaging in an online discussion forum developed and contributed to by CoRP members (http://sacmecorp.blogspot.com/)

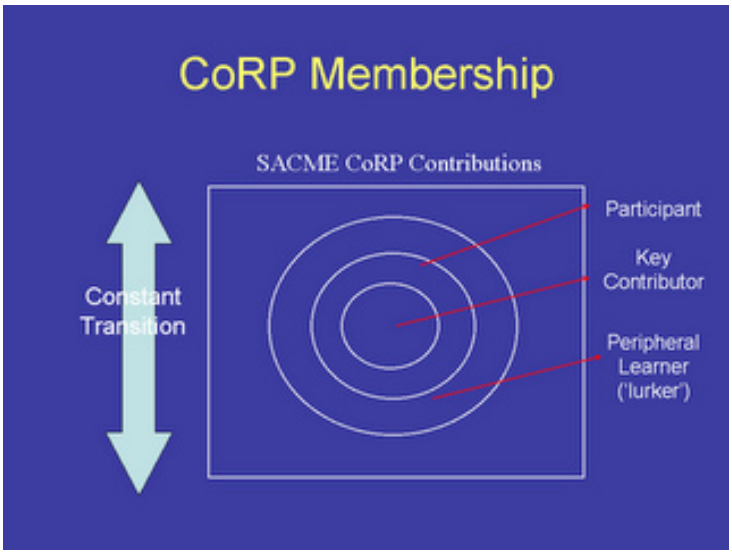
- Targeted one-hour web-conferencing learning opportunities pertaining to key systematic review topics (e.g. **January 31st 2008 "Searching for Evidence — The Reviewer's Perspective"**)
- Circulating key literature (e.g. **Iain Chalmers narrative**) for discussion through teleconference, email, or a discussion forum within web-enabled software programs.
- Face-to-face learning opportunities at the bi-annual SACME meetings.

"I Don't Think I'll Have The Time to Be a Member…"

A primary objective is to increase the interest in and understanding of systematic reviews in CME. At its core is the intention for members to come together as a community to share in a common interest and pursuit of understanding of systematic reviews. It should be recognized that COPs often have varying levels of member engagement and include: (1) key participants (e.g. central contributor to the CoRP) (2) key contributors (involvement at web-conferences, searches the Blog, hands-on work intermittent)[2] and (3) peripheral learners (moves in and out of participation, listens into conversations and discussions, but does not engage in hands-on work). What remains important to our CoRP are the learning opportunities available to you and the contributions you make to the discussions and sharing of stories with other community members.

[1]Learning on the run is a process involving a set of skills, tools and strategies that transforms one's clinical and non-clinical experiences into opportunities for learning. Bankey R, Campbell C, Horsley T. (2007) Lifelong Learning Series: Learning on the run. The Royal College of Physicians and Surgeons.

[2]These are defined solely for the purpose of our Community to provide examples of levels of participation and are not to be taken as concrete, accepted, definitions within the literature.



Can I become a member of the Community?

Absolutely! If you are interested in joining fellow SACME members in the discussion, debate, and creation of systematic reviews (from an end-user or producer perspective), please send an email stating your interest to thorsley@rcpsc.edu. We look forward to hearing from you!

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Triangles, Change and Websites: The Role of the AAMC in Supporting Continuing Education in the Academic Medical Center: The CME Delta

By Dave Davis, MD, Association of American Medical Colleges (AAMC)

Imagine a triangle – one of those isosceles things, with a flat base and two equal, sloping sides. The Greeks used it as a capital delta. Often enough, that triangle stands for change. Change is what many of us have been about in SACME, and now in the Association of American Medical Colleges (AAMC). And that's what this little piece is about.

Why change what we do in CME? Many forces compel us to modify how we deliver, integrate and evaluate CME, as difficult as that is. Here's just a little sample, drawn mostly from my days as a CME director/dean/whatever: big deans want us to be in the black, could care less about an over-dependence on commercial support (in fact often care less about CME; maybe another topic). Faculty members are busy, busy, less interested in changing the "model" or delivery of CME, often leery of interactivity, innovation, evaluation. It's rare when they see CME as a career path (research, yes, administration, yes, clinical work, yes, rarely CME). In Canada, the accreditation criteria ask for proof of "research in CME": okay, this is great, but research is done in another building, down the hall, in health services departments, in educational research centers, not often enough and hard to do in CME offices. In the US, the ACCME and others tell us that we need to be measuring the performance and health care outcomes of physicians, not just their presence and happiness in a conference setting. There's the whole movement toward competency assessment. Oh, man.

And then of course there are forces that argue against change, making our work even more difficult: there's the issue of overall funding, lack of integration with our health care systems, lack of recognition of the potential for our units by deans, CEOs and others. Lack of training of our staff beyond their current roles. A business model based on the conference. The notion that the CME Office equals the Conference Office. This list could be a book.

What's a CME provider to do?

There are of course many organizations which have at least some of these issues as their mandate, clearly and primarily SACME. At this broad, kind of 20,000 foot level, there are also things that the AAMC can do. For example, with input from SACME and others, AAMC can advocate for CME providers and their need to change at the deans' tables, and elsewhere. It

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can argue for increasing the opportunities for research and/or educational funding, help in the training of CME providers, support faculty members in a career path leading to advancement in CME or in research directions. It can encourage, facilitate and promote best practices in CME. It can link CEOs and deans to understand the linkages between CME and QI, the education and service sides of the house. And this is just a partial list. And we've really only just begun.

The new CE and improvement website: changing CME, improving practice

A small piece of this supportive puzzle is the new Continuing Health Care Education and Improvement website at the AAMC. Not trying to duplicate the excellent SACME site (but heavily linked to it), the site attempts to: promote faculty development in CME; broaden CME to include QI and performance improvement PI; enable easier access to research dollars; and, of course, promote meetings, new findings in CME, QI and PI, etc. Who's it for? While it is intended for members of SACME, primarily representing the leadership in CME. It is also intended for our faculty members, our hospital affiliated colleagues, current and potential research partners, those in the academic societies, deans and CEO's. Many of these folks are already members of the CME Section of the AAMC's Group on Educational Affairs, the host of this site. If your faculty colleagues and deans are not members, feel free to push the site to them. Heck, feel free to push it to anyone whom you think it could benefit.

And, of course, feel free to visit the site itself at www.aamc.org/members/gea/cmesection When you're there, think of the triangle, the delta for change: this website- along with the Society, our colleagues elsewhere- could be its base, the start of changing CME.

News from the American Medical Association

By Alejandro Aparicio, MD, FACP, Director, Continuing Physician Professional Development, American Medical Association

2007 was a very busy year for the Division of Continuing Physician Professional Development and the rest of the Education Group at the American Medical Association, as I am sure it was for all of you. In the last few months we produced four webinars: two on the Physician Recognition Award (PRA) Credit System rules and two on Performance Improvement (PI) CME. The PI CME webinars included information about the AMA-convened Physician Consortium for Performance Improvement (PCPI) and other organizations that have produced performance measures. These performance measures can be useful tools for CME providers that are developing PI CME activities. One of the PI CME webinars focused on hospitals, while the other focused on specialty societies. Each had a presentation by a CME provider from the target audience group discussing how they had been able to develop PI CME activities in their setting. We plan to continue our webinar offerings in 2008, and we will emphasize the newer modalities of CME without forgetting the traditional formats, which continue to be important and effective options for any CME program — depending on the needs of its learners.

The 18th Annual Conference of the National Task Force on CME Provider/Industry Collaboration was held October 17-19 in Arlington, Virginia. The planning committee was chaired by Pamela Mason, Director of Medical Education Grants at AstraZeneca, and co-chaired by Peter Vlasses, PharmD, Executive Director of the Accreditation Council for Pharmacy Education. The theme for the conference was "Collaboration to Improve Patient Care: A Call to

Action". It was very well attended, with more than 700 participants.

Conference highlights included the Schickman Lecture, delivered by Robert D. Fox, EdD, titled "Aligning for the Future: Building CPD for Physicians and Surgeons," for which Dr. Fox received a well-deserved standing ovation. Another highlight was the always popular case study-based session, "Working Together Within the Guidelines," during which panelists representing the perspectives of the AMA Council on Ethical and Judicial Affairs, the U.S. Food and Drug Administration, the Pharmaceutical Research and Manufacturers of America, the Accreditation Council for Continuing Medical Education, and the Office of the Inspector General discussed whether the scenarios would comply with the requirements/rules of each of the entities represented in the panel. Other plenary sessions focused on overall trends in, and perceptions of, CME and collaboration. Breakout and case-study sessions helped attendees focus on practical topics, including professionalism in the CME community, resolving conflicts of interest, successful examples of outcomes measurements, and grant application procedures.

The 19th Annual Conference will take place October 21-23 in Baltimore, Maryland. You can visit www.ama-assn.org/go/cmetaskforce to view/download slide presentations from this year's conference, including Dr. Fox's presentation, and for information about the 2008 conference. We are very fortunate that Dr. Vlasses has agreed to chair the planning committee and that SACME's own President-elect, Melinda Steele, MEd, has graciously accepted the role of co-chair for 2008 - and chair for the 20th Annual Conference which will take place in 2009 in Arlington, Virginia.

The work of the AMA's "Initiative to Transform Medical Education (ITME)" also continued in 2007. Besides the report published in June (www.ama-assn.org/ama1/pub/uploda/mm/16/itme_final_rpt.pdf), a follow up working conference was held in December. It focused on defining the medical education learning environment, identifying and prioritizing factors that affect learner outcomes, assessing current efforts for improvement, and creating recommendations for changes that will mitigate negative and enhance positive factors. The report of the conference will be completed in 2008. Other ITME activities will include a report on Lifelong Learning to be presented to the AMA House of Delegates at the 2008 annual meeting, as well as a conference with the American Academy of Pediatrics, also with a report to the House of Delegates, on re-entry and retraining.

In 2008 we will be celebrating the 40th anniversary of the AMA House of Delegates' approval of the Physician Recognition Award (PRA) and its accompanying credit system. During those 40 years, the Council on Medical Education of the AMA has continued to evolve the PRA Award and credit rules and has increased the number of educational formats approved for credit, based on evidence that physicians' knowledge, skills or performance improve by participating in them. The evolution of the credit system has benefited from the CME community's input and from cooperative relationships with the American Academy of Family Physicians and the American Osteopathic Association credit systems. Over the years, multiple other organizations have come to see the value of CME in helping physicians remain competent and improve the care they provide to their patients, such as licensing boards and the Joint Commission, and they have added participation in CME to their requirements. The results of the research on the effectiveness of CME have validated that decision.

I started this column by saying how busy 2007 probably was for all of us. I do hope that 2008 is just as busy. CME is important to physicians and to the patients that benefit from their increased knowledge, improved skills and enhanced performance, based on ever-expanding new scientific evidence. We are very fortunate; our work is important. And that should go a long way in helping to make 2008 a Happy New Year for all in the CME community.

Backing It Up With Evidence: the RDRB, A Literature Database for Continuing Education Professionals

By Laure Perrier, MEd, MLIS
RDRB Manager

Access To Over 16,000 Citations

The RDRB (Research and Development Resource Base) contains over 16,000 citations on continuing education, knowledge translation, guideline implementation and related areas. Search the RDRB at no cost online at: **www.cme.utoronto.ca/search**.

The RDRB provides the convenience of "one-stop shopping" by collecting relevant articles from a wide variety of sources, and housing them in one searchable collection. Of interest to administrators, researchers, and practitioners is quick access to literature on a multitude of subjects that specifically focus on continuing education. The following is a sample of the searches performed in one week on the RDRB and provides a snapshot of the breadth of topics covered: evaluation, e-learning, needs assessment, communities of practice, communication skills, and mentorship.

New! Time-Saving Features

The RDRB now offers the option of limiting results to a particular time period. If articles published within the last year are of interest, selecting Advanced Search from the menu will allow users to identify the years they would like to view for their results.

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

These results can now be saved directly to popular reference management software including Reference Manager, EndNote, and RefWorks. This is of particular interest for anyone using these tools for managing larger projects.

More recently, a Taxonomy was added and can be accessed by selecting Help from the menu. This can be glanced over to identify search terms that would help expand a search. One example of its usefulness is when searching a topic such as "academic detailing". Scanning the Taxonomy indicates that the user could also search the term "outreach visit" and this would also present results that may be relevant. Alternatively, the Taxonomy can be scanned for search terms when users feel certain there is a body of literature on their topic, but are having trouble finding relevant results with the terms they are using.

Visit this powerful database of literature anytime online at **www.cme.utoronto.ca/search**. Questions are answered and help is available by sending an email to: rdrb.cme@utoronto.ca.

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The Alliance for Continuing Medical Education; The Society for Academic Continuing Medical Education; The Royal College of Physicians and Surgeons of Canada; Canadian Association for Continuing Health Education; The Knowledge Translation Program at the Li Ka Shing Knowledge Institute, St Michael's Hospital; Continuing Education and Professional Development, University of Toronto.

Questions in Practice, Answers from SACME.org

By Anne Taylor-Vaisey, MLS

An association creates a Web site primarily to conduct its business—membership, meetings, officers, publications. But a Web presence can provide much more, and in my work as a health sciences librarian I frequently use the SACME site as a virtual reference tool, a place to find answers to clients' questions. The SACME site is dynamic, rich in content and easy to navigate. Here is a selection of questions I've answered using SACME.org, and the pathways to those answers. Q: At a recent SACME meeting I heard something about an Armadillo society. Was this a real society? See the *Site Map* (http://www.sacme.org/index.cfm?&id=1582) to view SACME.org at a glance.

A: Yes and no. In 1990, *One of the [SMCDCME] past-presidents suggested the group be called the "Armadillo Society," out of regard for the relative sluggishness and unimportance of its members*. Read more here: Caplan RM. History of the Society of Medical College Directors of Continuing Medical Education (SMCDCME): The first twelve years, 1976-1988. *JCEHP* 1996; 16(1):14-24.

Path: In the search box, type <armadillo> and retrieve the *SACME History* page. This page contains highlights of the first 20 years of SACME (formerly SMCDCME) and some links to sources. A sub-page highlights the past presidents. (For more about SACME see *About Us*.)

Q: I've been asked to do a presentation on teaching evidence-based medicine and I need to get up to speed, and fast. I also want to include some recent articles in my hand-outs.

A: The *Evidence-Based Medicine Resources* page provides the basics of EBM. The link *Run your own search on PubMed* retrieves hundreds of articles on teaching EBM. You can download some presentations from AAMC's MedEdPORTAL (free registration required).

Path: Go to *Research Resources*, then the sub-page *Evidence-Based Medicine Resources*. To find the MedEdPortal and similar sites, go to *CME Best Practices: FAQs & Toolkits.* Also, type <evidence-based medicine> in the search box.

Q: At formal CE events I think I learn as much during the breaks as I do from the presentations. Has anyone done any research on this?

A: In 2001, the *JCEHP Award for Excellence in Research* went to: Tipping J, Donahue J, Hannah E. Value of unstructured time (breaks) during formal continuing medical education events. *JCEHP* 2001;21(2):90-96.

Path: Type <events breaks> in the search box to reach the *SACME Award Winners* page. This page lists winners of the *JCEHP Award,* SACME's *Distinguished Service in CME* and the Fox Award, and also lists SACME grant recipients.

Q: We are a new CME office and my Dean wants me to research policies and procedures at other medical schools. He wants this information yesterday.

A: You need survey data. Since 1996 SACME has produced its *Biennial Survey*, and since 1998 the ACCME has produced *Annual Report Data*. Links to all years are available.

Path: Click on *CME Survey Data* on the SACME home page. Also check out *CME Best Practices*.

Q: What are the accreditation practices in Europe?

A: *European accreditation is granted to organizers who apply for the accreditation of a CME activity through the European Accreditation Council for CME (EACCME). The EACCME is run by the European Union of Medical Specialists (UEMS).*

Path: Type <accreditation Europe> in the search box. Or go to *CME Best Practices,* then the sub-page *Accreditation & Maintenance of Certification*. This page links to accrediting bodies for the U.S., Canada and Europe, as well as the new SACME position paper on letters of agreement (Steele & Schaffer), suggested reading, and glossaries of terms.

Q: I want to start a CME library. What books should I read and to what journals or newsletters should I subscribe?

A: SACME.org links to publications from many medical education organizations, and even links to the latest issues of the field's major journals. A *JCEHP* paper about a list of books and journals recommended by a panel of CME professionals will help you build your library.

Path: Go to *Research Resources*, then the sub-page *News Sources, Journals & Blogs*. Explore the publications listed, and for some advice, link to: Olson CA, Tooman TR, Leist JC. Contents of a core library in continuing medical education: a Delphi study. *JCEHP* 2005 Fall;25(4):278-88. A link to their list of recommended books and journals is provided. For SACME publications, go to *Publications*, and link to pages for *INTERCOM*, *JCEHP* and the Biennial Survey.

Q: There is a lot of discussion these days about ethical and professional behavior in the health professions. Is there such a thing as a written code of ethics for CME professionals?

A: Not specifically, but a number of medical and health organizations have produced codes of ethics, and much has been written about professionalism and ethics. In CME a major issue is, of course, compliance with the ACCME's Standards for Commercial Support for CME. A recent position paper on letters of agreement (endorsed by SACME; see related announcement in this issue) addresses this issue. Links to all the above, as well as to selected readings, are available at SACME.org.

Path: Go to *CME Best Practices*, then the sub-page *Ethics & Professionalism*. Also, type <ethics> in the search box.

Q: I'm working with a group of colleagues on a research proposal and we are about to seek funding. How do I find funding sources and where can I get some advice?

A: SACME members may apply for SACME research grants. SACME.org lists other granting sources, as well as resources on how to apply for and write grants.

Path: For information about SACME research grants, go to *Research Resources*, then the sub-page *SACME Research Grants*. See also *Granting Sources* on the *CME Best Practices* page. Or type <grants> in the search box. Get many of your questions answered at SACME.org!

Online Educational Activity in Development

By Lois Colburn

Over the course of the last several months, SACME and the Alliance for Continuing Medical Education have collaborated to develop an online educational activity for faculty about their roles and responsibilities in continuing medical education and promotional education. The ultimate goal of this project is to develop a national database, limited to CME providers and pharmaceutical and device representatives to determine if faculty for their educational activities understand the differences between certified CME and promotional education. This effort is especially timely given the Senate Finance Committee Report as well as the recently released Macy report. More information regarding the faculty initiative project will be presented at CME Congress 2008 in Vancouver.

Those involved in developing the content are: James Leist (project director), Dave Davis, Walt Wolyniec, Mark Schaffer, Jann Balmer, Melissa Newcomb, Beverly Hughes, Deborah Sutherland and Lois Colburn.

We hope to have this final product available at the Congress meeting in May, so stay tuned for further details.

A Position Paper on Letters of Agreement for Commercial Support Grants in Support of Continuing Medical Education Activities: The Accredited Provider's Position

By Melinda Steele, MEd

The use of funds provided by commercial supporters has, over the years, become integral to the development and conduct of continuing medical education activities by providers from all venues: medical schools, hospitals, associations, and medical education companies. Although some may argue about the appropriateness of such funding, the Accreditation Council for Continuing Medical Education (ACCME) has tried to put into place policies and standards to reinforce the independence of accredited providers when utilizing such funding. The Letter of Agreement (LOA) is a key element to the documentation of this independence.

One of the frustrations accredited providers have endured over time is the inclusion by commercial interests of clauses that often are not reflective of either the spirit or the intent of the ACCME Standards for Commercial Support. In fact, some of these clauses are absolutely contrary to the maintenance of that independence. Melinda Steele, MEd and Mark Schaffer, EdM, as leaders in various CME professional associations, have discussed these issues with their colleagues and have presented sessions on this topic at various conferences. Over time they have discovered that the frustrations and issues of all accredited providers had many common threads. In response to these dialogues, they have written a position paper to address the issue of Letters of Agreement from the perspective of the accredited provider.

Access to the position paper and a release statement can be found on the SACME web at www.sacme.org (direct link http://www.sacme.org/index.cfm?newsid=100&pagepath=News_Events&id=1018)

Intercom

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

SACME Listserv: sacme@lists.wayne.edu.

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UPCOMING EVENTS

Ottawa International Conference on Medical Education (13th)
March 5-8, 2008
Melbourne Exhibition and Convention Centre
Melbourne, Australia
http://ozzawa13.com/

MedBiquitous
May 13-15, 2008
Sheraton Baltimore City Center
Baltimore, MD, USA
http://www.medbiq.org/

2008 SACME Spring Meeting
in conjunction with CME Congress 2008
May 29-31, 2008
The Hyatt Regency
Vancouver, BC, Canada
http://www.cmecongress.org/Home.htm

19th Annual Conference of the National Task Force on CME
Provider/Industry Collaboration, October 21-23, 2008,
Baltimore Marriott Waterfront
Baltimore, Maryland
http://www.ama-assn.org/ama/pub/category/4455.html

2008 SACME Fall Meeting
in conjunction with AAMC Annual Meeting
October 31 - November 5, 2008
Grand Hyatt, and Marriott Riverwalk
San Antonio, Texas
http://www.aamc.org/meetings/annual/2008/start.htm

34th (2009) Annual Alliance for CME Conference
January 28-31, 2008
San Francisco Marriott
San Francisco, CA
http://www.acme-assn.org/

See also *News & Events* at www.sacme.org