

SOCIETY FOR ACADEMIC  
CONTINUING MEDICAL EDUCATION

**Survey for 2002**  
**Descriptive Results**

**Collected February 2002**  
**and including program data for 2000–01**

Prepared by the Survey Subcommittee  
of the Research Committee

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April, 2002

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### Introduction

Members of the Society’s Research Committee survey CME units at medical schools to collect and disseminate information about policies and practices relating to continuing medical education as carried out by colleges and schools of medicine in the United States and Canada. This current survey and its report are intended to fulfill several functions. It provides an overview for all Society members concerning programming and attendance. It provides newer members with an overview of areas and activities that might otherwise take several years to acquire through informal discussions. It provides longer term members an update on general information and a clearer understanding of specific activities. For all members it provides the occasion to compare their CME units with those of other schools, to recognize the extent to which they are similar to or different from the other schools, and to suggest ways to improve the functioning of their units.

The survey focuses on continuing medical education for physicians. Many units providing CME also provide continuing education for other health professions. Recognizing the purpose of the Society, the survey does not include information on activities aimed primarily at groups

other than physicians. This focus provides information that is more comparable across medical schools.

All attempts to represent reality have their limitations. The survey is an excellent way to present aggregate data on a number of dimensions. However, it cannot represent the complex factors operating simultaneously at any one school. The report provides a general perspective. Additional inquiry would be necessary to draw conclusions about any one school.

The limited size of the population – 141 medical schools (125 in the United States and 16 in Canada), 94 of which are currently members of the Society – and the typical response rate (60 to 85 schools) provides sample sizes with the statistical power to detect only substantial differences on measures that are significant at the .05 level (5 chances in 100 that the observed difference is not random). However, differences of moderate and small size may be important for administrative and policy decisions. Therefore, this descriptive report presents data and discusses them briefly in the context of factors known to be operating in the CME environment. Issues of particular interest are typically addressed individually in subsequent articles published in professional journals. These articles are more detailed in both the statistical analysis of data and discussion of results.

TABLE 1. Percent of Institutions Returning the Survey by Geographic Region

	North-East	Mid-West	South	West	Canada	Total
Number of Institutions	28	27	26	12	7	100
Number Returning Questionnaires	20	19	23	8	4	74
Response Rate	71%	70%	88%	67%	57%	74%

TABLE 2. Response Rates for Biennial SMCDCME Surveys

Year	Number Sent	Number Returned	Response Rate
1986	120	63	53%
1988	120	58	48%
1990	118	72	61%
1992	117	65	56%
1994	114	75	66%
1996	121	89	74%
1998	122	82	67%
2000	112	62	55%
2002	100	74	74%

The methods used to collect the data and some comments concerning the representativeness of data are presented below. The descriptive results include three sections that are routinely included in the surveys: current trends, programs and attendees, and course fees. Three additional sections have been periodically included in previous surveys and updated results are presented in this survey: faculty honoraria, CME director characteristics and salary, and financial arrangements for CME units. Five sections are on topics unique to this survey. The report text concludes with a summary of the patterns seen across the various areas included in the survey. The responding institutions are acknowledged at the end.

## Methods

The questionnaire was developed by members of the Survey Subcommittee of the Research Committee of the Society. Its content was derived from items in previous surveys of the Society, suggestions of society members to the Research Committee, and suggestions developed by the Subcommittee as they revised the survey content. Items in the survey are introduced in the results section along with the results for the item.

The questionnaire was sent on January 21, 2002, to the senior ranking member of the 94 medical schools and colleges in the United States and Canada having members in the Society. A reminder to return the questionnaire was faxed to institutions that had not responded by the last week of February, 2002. The responses were returned from February through mid-March, 2002.

Table 1 presents the response rates in returning the questionnaire. Seventy-four of the medical schools (74%) returned the survey. As indicated in Table 1, response rates by geographic region ranged from 57% in Canada to 88% in the southern United States.

Table 2 summarizes the previous response rates for the biennial survey. The response rate for this survey is as high as any previous survey. While the reason for the high response rate is not certain, it may be due in part to the lower number of schools that currently have members in the Society – generally more than 15 fewer schools than in the past. Schools with less focus on CME may be less likely to maintain continuity of membership. Schools maintaining continuity in membership may have a higher response rate.

Although the medical schools responding to past surveys and the present survey are not identical, a general assumption is made that they are sufficiently similar that comparisons are made between current data and parallel data reported previously. However, trends across time must be interpreted cautiously because some change across years will be due to differences in the specific institutions returning the surveys across the years.

The return of the survey did not necessarily mean that data were available for every item. Some items did not apply to all institutions and some institutions did not complete all items. A major factor in providing data was the extent to which the CME unit already kept data in a format similar to that requested by the survey. For example, data for physician oriented programs were already separate from data for other programs, attendance data were kept separately for external participants and internal participants. When an item did not apply to an institution it was sometimes left blank and the distinction between missing data and "does not apply" or "zero" was not always clear. The number of responses on which the data are based varies from item to item and therefore the total number of responding schools is usually presented for each item. Also, median values (50th percentile) are reported when extreme values for a few institutions would disproportionately affect mean values.

Data are generally reported as submitted in the questionnaire. An exception is dollar values reported by Canadian schools, presumably in Canadian dollars. Those values were converted to U.S. dollars by multiplying by .65.

Two time frames are used in presenting data. Some items concern aspects of CME activities over a 12 month period. Information for these items was requested for the last academic year (typically 2000-01) or other recent annual reporting period used by the institution. Other items asked about operations and opinions at the time the survey was being completed – about February, 2002. The applicable time period is shown when data are presented for more than one year.

## Descriptive Results

### Current Trends

The survey included a section asking for impressions about current trends for several aspects of CME at medical schools. The information represents the perception of directors of CME units concerning trends at the time the questionnaire was completed (February, 2002). The distribution of medical schools on the responses is presented in Table 3 along with the data for the same items when they were asked in previous surveys. The mean response for each item (coded from 1 = "decreasing a lot" to 5 = "increasing a lot" is also presented. With 3.0 reflecting no average change, means < 3 indicate a decreasing trend and means > 3 indicate an increasing trend.

Many means fall between 2.8 and 3.2, indicating little overall change across medical schools

The number of courses for external physicians is stable overall – the very slight increase is consistent with the slight increase in Table 5. It is the least change across all previous years.

The responses indicate that the number of external physicians per course is overall stable. In most previous years the trend has been slight increases or stable.

Attendance at courses at "pleasure" locations is lower on average. It is the largest drop across several years of either stable or slightly lower attendance.

Faculty interest for participating in the medical school's CME is stable overall. It is the first year that interest has not been increasing at least slightly.

Faculty interest for participating in CME produced by other sponsors is largely stable and similar to previous years.

Financial support for CME from the university is lower overall, although not changing at the majority of schools. The trend over years is continuing slight decreases in support from the university.

Financial support from commercial companies is decreasing overall. Over the years the patterns of change have varied across increases and decreases. This change may offset some of the increase noted two years ago.

Quality of courses is viewed as increasing overall. This continues the trend across years for reports of increasing quality.

Time between registering and the course date is viewed as decreasing slightly. The responses are similar to those in past years, showing a continuing trend to later registration across time.

An overall summary of current trends is that the largest increase is for the reported quality of courses. Modest decreases are occurring in attendance at pleasure courses, financial support from commercial companies, financial support from the university, and time between registering and the course date. For the other items, the overall trend is close to no change, with some individual institutions experiencing changes in both decreasing and increasing directions.

When looking at trends across years, the biggest change is the shift from recently increasing commercial support to now decreasing commercial support. The number of courses for external physicians and faculty interest in participating in the school's CME are both now stable, a change from past patterns of slight to moderate increases. Attendance at pleasure courses decreased, a change from the stability of recent years

TABLE 3. Distribution of Medical Schools on Current Trends in Various Aspects of CME

	Year (Reported in February)	Current Trend Is:					Mean [1-5]	Total Schools
		Decreasing A Lot [1]	Decreasing A Little [2]	No Change [3]	Increasing A Little [4]	Increasing A Lot [5]		
Number of Courses for External Physicians:	1990	0%	10%	29%	46%	15%	3.7	70
	1992	3%	16%	28%	50%	3%	3.3	64
	1994	0%	27%	26%	43%	4%	3.2	70
	1996	2%	23%	36%	35%	4%	3.2	88
	1998	2%	21%	24%	42%	11%	3.4	81
	2000	2%	19%	16%	55%	8%	3.5	62
	2002	3%	31%	26%	35%	5%	3.1	74
Number of External Physicians per Course:	1990	0%	20%	33%	37%	10%	3.4	69
	1992	2%	19%	43%	35%	2%	3.2	63
	1994	1%	34%	34%	27%	4%	3.0	71
	1996	1%	33%	38%	27%	1%	2.9	88
	1998	1%	33%	27%	36%	3%	3.1	80
	2000	5%	26%	14%	53%	2%	3.2	62
	2002	3%	37%	29%	27%	4%	2.9	73
Attendance at Courses at "Pleasure" Locations:	1990	3%	12%	60%	23%	2%	3.1	65
	1992	5%	15%	64%	15%	1%	2.9	61
	1994	10%	21%	47%	21%	1%	2.8	71
	1996	11%	30%	41%	17%	1%	2.7	83
	1998	3%	14%	54%	29%	0%	3.1	79
	2000	5%	11%	63%	21%	0%	3.0	57
	2002	13%	24%	56%	7%	0%	2.6	70
Faculty Interest in Participating in Your School's CME	1990	0%	3%	31%	53%	13%	3.8	58
	1992	3%	6%	37%	48%	6%	3.5	63
	1994	1%	12%	41%	36%	10%	3.4	73
	1996	2%	24%	36%	31%	7%	3.2	89
	1998	5%	21%	33%	32%	9%	3.2	81
	2000	7%	16%	34%	37%	6%	3.2	62
	2002	3%	28%	35%	30%	4%	3.0	74
Faculty Interest in Participating in Other Sponsors' CME	1990	0%	5%	55%	33%	7%	3.4	70
	1992	5%	4%	69%	20%	2%	3.1	55
	1994	2%	4%	79%	13%	2%	3.1	62
	1996	1%	11%	69%	18%	1%	3.1	78
	1998	4%	7%	66%	20%	3%	3.1	74
	2000	2%	7%	67%	20%	6%	3.2	62
	2002	2%	2%	84%	10%	2%	3.1	59
Financial Support for CME from University:	1990	6%	21%	54%	16%	3%	2.9	70
	1992	9%	25%	52%	12%	2%	2.7	64
	1994	12%	18%	55%	14%	1%	2.7	73
	1996	16%	25%	47%	11%	1%	2.6	89
	1998	11%	10%	59%	18%	1%	2.9	80
	2000	5%	16%	60%	17%	2%	2.9	62
	2002	11%	19%	63%	7%	0%	2.7	72

(TABLE 3 continues on next page)

TABLE 3 (continued). Distribution of Medical Schools on Current Trends in Various Aspects of CME

	Year (Reported in February)	Current Trend Is:					Mean [1-5]	Total Schools
		Decreasing A Lot [1]	Decreasing A Little [2]	No Change [3]	Increasing A Little [4]	Increasing A Lot [5]		
Financial Support for CME from Commercial Companies:	1990	0%	13%	39%	39%	9%	3.4	69
	1992	2%	23%	33%	37%	5%	3.2	64
	1994	16%	39%	23%	19%	3%	2.5	73
	1996	8%	44%	19%	25%	4%	2.7	89
	1998	15%	19%	28%	36%	2%	2.9	81
	2000	2%	22%	20%	51%	5%	3.4	62
	2002	5%	49%	23%	22%	1%	2.6	74
Quality of Courses for External Physicians:	1990	0%	0%	28%	55%	16%	3.8	67
	1992	0%	0%	34%	55%	11%	3.8	64
	1994	0%	4%	25%	58%	13%	3.8	72
	1996	0%	1%	33%	56%	10%	3.8	89
	1998	0%	0%	30%	62%	8%	3.8	79
	2000	0%	2%	28%	57%	13%	3.8	62
	2002	0%	1%	42%	46%	11%	3.7	74
Time between registering & course date:	1996	13%	21%	56%	10%	0%	2.6	89
	1998	12%	24%	51%	11%	1%	2.7	78
	2000	8%	28%	50%	11%	3%	2.7	60
	2002	5%	31%	54%	10%	0%	2.7	74

and more than decreases in the early 1990's. The trends across time on the other measures have been generally similar for several years. Sustained trends are for appreciable increases in the quality of courses and continuing decreases in financial support from the university and in time between registering and the course date. Generally stable across years are the number of external physicians per course and faculty interest in participating in other sponsors' CME activities.

## Programs and Attendees

Difficulties sometimes arise because people use the same terms to mean different things. Respondents must use terms with common definitions for responses to be comparable. Therefore, this section of the questionnaire began with a page of definitions concerning courses and attendees. The text is reproduced as the Appendix. The defined terms were then used to specify a primary interest in responses concerning live multiple hour and multiple day courses, conferences and seminars oriented to external physicians.

**Courses, credit hours, and attendees.** Table 4 presents the distributions of medical schools on the annual number of courses oriented to external physicians, on the category 1

credit hours designated for these courses, and on the total attendance at these courses by physicians and others external to the institution. The 25th, 50th and 75th percentiles for these variables are shown in Table 5 for eight previous surveys as well as for the current one.

Medical schools vary widely on the annual number of courses oriented to external physicians (Table 4). Table 5 shows a doubling in number of courses from 1984-85 to 1990-91. From then to 1994-95 the number of courses appears to have decreased slightly. In 1996-97 the number of courses returned to the 1990-91 levels. Since 1996-97 the number of courses has increased and are currently (2000-2001) at the highest levels seen.

As shown in Table 4, the distribution on total course CME hours is fairly wide. The 25th, 50th, and 75th percentiles are shown in Table 5. The number of course hours increased until 1992-93, remained fairly stable through 1996-97, then increased in 1998-99 and are at approximately the same (perhaps slightly lower overall) in 2000-01. The pattern of a higher number of courses and a stable number of course hours suggests that the number of shorter courses has increased appreciably and the number of longer courses has decreased somewhat.

TABLE 4. Distribution of Medical Schools on Annual Number of Courses, CME Hours, External Physician Participants, and Other External Participants

Courses, & Conferences for External Physicians	Medical Schools	Course CME Hours	Medical Schools	External Physician Participants	Medical Schools	Other External Participants	Medical Schools
0-19	5	0-199	5	0-999	9	0-999	18
20-39	9	200-399	12	1,000-1,999	15	1,000-1,999	14
40-59	14	400-599	10	2,000-2,999	5	2,000-2,999	17
60-79	13	600-799	9	3,000-3,999	13	3,000-3,999	10
80-99	10	800-999	8	4,000-4,999	5	4,000-4,999	4
100-119	6	1,000-1,199	5	5,000-5,999	6	5,000-5,999	2
120-139	4	1,200-1,399	4	6,000-7,999	2	6,000-7,999	2
140-199	4	1,400-1,599	4	8,000-9,999	4	8,000-9,999	0
200-over	6	1,600-1,799	5	10,000-11,999	4	10,000-12,999	3
		1,800-1,999	1	12,000-15,999	3		
		2,000-over	6	16,000-over	3		
Total Schools	71	Total Schools	69	Total Schools	69	Total Schools	70

Note: Data are for the year from July 2000, through June 2001, or the closest 12 month reporting period.

The third section of Table 4 shows that the attendance by external physician participants also varies widely. Table 5 presents the 25th, 50th, and 75th percentiles for recent surveys. The number of external physician participants increased until 1992-93, was generally stable in 1994-95, and has increased since 1996-97.

The number of other external participants is not always recorded in a way that is convenient to report. For the courses oriented to external physicians, the last section of Table 4 shows that the number of other external attendees clusters fairly tightly at less than 4,000 for most schools. Table 5 presents the 25th, 50th, and 75th percentiles. Again increases occurred through 1992-93, then an appreciable increase in 1998-99 and a slight increase in 2000-01.

**Other CME activities.** Medical schools can engage in a number of additional CME activities. Data on the other formats for "live" CME are presented in Tables 6 and 7. Data on enduring self-study CME activities are presented in Table 8. The column ranges reflect natural clustering of medical schools; the ranges are usually not equal across columns.

The first section of Table 6 displays the number of presentations at county medical societies and local hospitals that were arranged by the CME unit. Presentations of this type are arranged by just over half of the medical schools, although the number of presentations varies substantially. The results across recent years suggest that fewer medical schools are arranging these presentations.

Some CME units conduct conferences by telephone. Table 6 presents the number of medical schools presenting single session telephone conferences and multiple session telephone conferences. The substantial majority of CME units are not involved with either single or multiple session telephone conferences. The results appear to be fairly stable across years, with a tendency for few less schools to hold single session conferences and a few more schools to hold multiple session conferences.

The survey also asked about single and multiple session closed circuit televised conferences. Table 7 shows that the substantial majority of medical schools are not involved with television conferences, although about a quarter of the schools are involved with some single session televised conferences. The results appear to be fairly stable across years.

This year the survey asked how many of the televised conferences were transmitted by satellite and how many were two-way interactive. The results are presented in Table 7. About half (54%) of single session video conferences are interactive and 30% of multiple session video conferences are interactive. The use of interactive communication is generally lower than two years ago. Regarding method of transmission, a minority (36%) of single session conferences are broadcast by satellite while the majority (70%) of multiple session conferences are broadcast by satellite. This reverses the pattern of satellite (rather than closed circuit) broadcasting across single and multiple session televised conferences found two years ago.

In recent years the survey asked about conferences broadcast over the Internet. As shown in Table 6, very few schools are

TABLE 5. Distribution (Quartiles) of Medical Schools on Annual Number of Courses Oriented to External Physicians, CME Hours, External Physician Participants, and Other External Participants

	Reporting Year	25th Percentile	50th Percentile	75th Percentile	Total Schools
Number of Courses for External Participants:	1984-85	16	32	52	47
	1986-87	22	34	56	56
	1988-89	29	46	60	61
	1990-91	30	61	100	61
	1992-93	32	57	94	71
	1994-95	31	50	78	84
	1996-97	32	61	96	81
	1998-99	34	67	104	61
	2000-01	48	70	109	71
Number of CME Hours Certified:	1988-89	257	415	653	59
	1990-91	284	468	944	60
	1992-93	314	554	1,114	72
	1994-95	243	507	1,000	82
	1996-97	302	617	1,087	81
	1998-99	477	754	1,540	60
	2000-01	398	786	1,321	69
Number of External Physician Participants	1988-89	1,000	2,078	3,300	59
	1990-91	1,200	2,039	3,957	61
	1992-93	1,240	2,552	5,000	73
	1994-95	1,273	2,537	4,538	82
	1996-97	1,519	2,815	4,959	81
	1998-99	1,418	3,314	5,481	59
	2000-01	1,437	3,536	5,571	69
Number of Other External Participants	1988-89	350	500	1,000	52
	1990-91	293	850	1,731	56
	1992-93	400	1,414	2,281	67
	1994-95	517	1,208	2,522	80
	1996-97	445	1,237	2,358	77
	1998-99	792	1,983	3,377	57
	2000-01	927	2,039	3,266	70

broadcasting either single session conferences or multiple session conferences by Internet and the number of schools involved has not changed appreciably over four years. Table 7 shows that for the 14 single session conferences, half involved two-way interactive communication. The three reported multiple session conferences involved two-way interactive communication. These results are similar to those two years ago.

The last section of Table 6 addresses individual tutorials and traineeships. Only a third of medical schools offer tutorials or traineeships and usually to a low number of individuals. Results across years suggest a an ongoing reduction in the number of schools and individuals involved in this type of CME.

Another form of CME is the self-study course using some type of enduring material. For several years Society surveys have asked about the total number of individuals participating

TABLE 6. Distribution of Medical Schools on Annual Number of Some Other Types of "Live" Externally Oriented CME Activities

	Reporting Year	0	1-50	51-100	101-200	201-400	>400	Total Schools
Number of School	1984-85	31%	37%	11%	15%	4%	2%	54
Sponsored Presentations at Local Medical Societies and Hospitals:	1986-87	18%	35%	11%	24%	5%	7%	55
	1988-89	25%	33%	22%	8%	6%	6%	72
	1990-91	23%	49%	5%	12%	9%	2%	57
	1992-93	32%	42%	17%	5%	3%	1%	72
	1994-95	38%	39%	4%	13%	4%	2%	53
	1996-97	40%	41%	9%	7%	2%	1%	80
	1998-99	46%	30%	10%	12%	0%	2%	57
	2000-01	46%	35%	13%	6%	0%	0%	71
	Year	0	1-10	11-50	>50	Schools		
Number of Single Session Telephone Conferences:	1988-89	83%	10%	6%	1%	72		
	1990-91	83%	12%	3%	2%	58		
	1992-93	86%	11%	3%	0%	71		
	1994-95	88%	6%	6%	0%	53		
	1996-97	86%	4%	6%	4%	80		
	1998-99	86%	6%	4%	4%	56		
	2000-01	96%	4%	0%	0%	71		
Number of Multiple Session Telephone Conferences:	1988-89	94%	5%	1%	0%	72		
	1990-91	88%	9%	3%	0%	57		
	1992-93	92%	4%	3%	1%	71		
	1994-95	89%	9%	2%	0%	86		
	1996-97	81%	13%	3%	3%	80		
	1998-99	86%	12%	2%	0%	57		
	2000-01	80%	17%	3%	0%	71		
Number of Single Session Video Conferences:	1988-89	71%	22%	1%	6%	72		
	1990-91	79%	16%	5%	0%	58		
	1992-93	76%	20%	4%	0%	71		
	1994-95	70%	29%	1%	0%	87		
	1996-97	70%	23%	6%	1%	80		
	1998-99	79%	12%	9%	0%	58		
	2000-01	76%	18%	3%	3%	71		
Number of Multiple Session Video Conferences:	1988-89	92%	8%	0%	0%	72		
	1990-91	86%	10%	3%	0%	58		
	1992-93	93%	4%	3%	0%	71		
	1994-95	83%	16%	1%	0%	81		
	1996-97	75%	21%	3%	1%	80		
	1998-99	75%	21%	4%	0%	57		
	2000-01	85%	14%	1%	0%	71		

(TABLE 6 continues on next page)

TABLE 6 (continued). Distribution of Medical Schools on Annual Number of Some Other Types of "Live" Externally Oriented CME Activities

	Year	0	1-10	11-50	>50	Schools
Number of Single Session	1996-97	95%	5%	0%	0%	80
Internet Broadcast Conferences	1998-99	93%	7%	0%	0%	57
	2000-01	93%	7%	0%	0%	71
Number of Multiple Session	1996-97	95%	5%	0%	0%	80
Internet Broadcast Conferences	1998-99	98%	2%	0%	0%	57
	2000-01	96%	4%	0%	0%	71
		0	1-20	21-60	61-300	Schools
Number of Individuals in Tutorials or Traineeships:	1984-85	39%	45%	8%	8%	53
	1986-87	42%	33%	16%	9%	57
	1988-89	46%	33%	16%	9%	72
	1990-91	48%	36%	8%	4%	61
	1992-93	49%	37%	8%	6%	72
	1994-95	54%	28%	9%	9%	80
	1996-97	52%	33%	5%	10%	80
	1998-99	54%	32%	12%	2%	57
	2000-01	68%	24%	5%	3%	71

TABLE 7. Communication Methods for Live Televised and Internet Broadcast CME Activities

Type of Activity	Year	Two-way Interactive	By Satellite	No. of Activities
Televised, single session	1998-99	94%	53%	172
	2000-01	54%	36%	225
Televised, multiple session	1998-99	66%	27%	79
	2000-01	30%	70%	37
Internet broadcast, single session	1998-99	40%	(NA)	5
	2000-01	50%	(NA)	14
Internet broadcast, multiple session	1998-99	100%	(NA)	1
	2000-01	100%	(NA)	3

in self-study for credit. The survey for 1992-93 expanded the questions in this area. It also asked for the number of self-study activities developed/produced, asked for the data separately by type of medium (written, audio, video), and added computer based self-study. The survey for 1994-95 further differentiated between computer self-study offered on disk or CD ROM and computer self-study offered by direct connection through the Internet.

Table 8 presents the distribution of medical schools on the number of self-study courses produced and the number of individuals given credit. In 2000-01, approximately two-thirds of the medical schools produced written self-study, a quarter produced audio self-study, less than half produced video self-study, a third produced computer self-study based on disk, and half produced computer self-study based on the Internet.

Over the most recent six years (since 1994-95), the number of medical schools involved in written self-study has decreased, in audio and video has been about the same, and in both computer CD ROM disks and over the Internet has increased. The last set of entries in Table 8 show the results of combining all CME formats. The number of medical schools offering one or more formats of self-study CME has increased over the years and now 80% of medical schools offer self-study CME in some format.

Looking at the number of individuals receiving credit, the most noteworthy result is that CME credit is received for using written self-study activities much more often than any other format. This pattern has been consistent over the years.

TABLE 8. Distribution of Medical Schools on Number of Annual Written, Audio, Video, and Computer Self Study Courses and Number of Individuals Receiving Credit for Them

		No. of Activities Produced				No. of Individuals Receiving Credit						Total Schools
		0	1-10	11-50	50-100	0	1-200	201-500	501-1,000	1001-10,000	>10,000	
Written Self-Study (including journals)	1992-93	56%	41%	3%	0%	68%	20%	8%	3%	1%	*	71
	1994-95	51%	43%	6%	0%	52%	26%	5%	6%	11%	*	82
	1996-97	46%	46%	8%	0%	51%	26%	8%	4%	11%	*	80
	1998-99	32%	57%	9%	2%	35%	23%	7%	8%	23%	4%	52
	2000-01	38%	40%	22%	0%	45%	25%	6%	6%	18%	0%	71
Audio Self-Study	1992-93	93%	6%	1%	0%	95%	4%	1%	0%	0%	*	71
	1994-95	78%	22%	0%	0%	82%	13%	1%	1%	3%	*	81
	1996-97	79%	21%	0%	0%	82%	16%	1%	0%	1%	*	80
	1998-99	77%	21%	2%	0%	83%	11%	0%	2%	4%	0%	47
	2000-01	72%	27%	1%	0%	79%	14%	3%	3%	1%	0%	71
Video Self-Study	1992-93	82%	13%	4%	1%	86%	9%	4%	1%	0%	*	71
	1994-95	56%	43%	1%	0%	65%	21%	5%	5%	4%	*	81
	1996-97	56%	43%	1%	0%	60%	32%	0%	4%	4%	*	80
	1998-99	60%	38%	2%	0%	62%	26%	0%	2%	6%	4%	50
	2000-01	59%	38%	3%	0%	70%	23%	6%	1%	0%	0%	71
Self-Study Computer SS: Disk	1994-95	85%	15%	0%	0%	91%	5%	3%	0%	1%	*	80
	1996-97	78%	21%	1%	0%	80%	18%	0%	0%	1%	*	80
	1998-99	69%	29%	2%	0%	71%	17%	0%	0%	0%	2%	48
	2000-01	63%	37%	0%	0%	69%	23%	5%	0%	3%	0%	71
Computer SS: Internet	1994-95	91%	9%	0%	0%	97%	3%	0%	0%	0%	*	79
	1996-97	75%	25%	0%	0%	80%	18%	1%	1%	0%	*	80
	1998-99	53%	45%	2%	0%	60%	32%	2%	4%	2%	0%	47
	2000-01	47%	40%	13%	0%	61%	19%	10%	7%	3%	0%	71
All Types of Self-Study Combined	1984-85	(not collected)				67%	17%	7%	5%	4%	*	54
	1986-87	(not collected)				51%	19%	21%	0%	9%	*	58
	1988-89	(not collected)				48%	32%	7%	6%	7%	*	72
	1990-91	(not collected)				55%	24%	3%	8%	10%	*	62
	1992-93	52%	37%	10%	1%	66%	16%	7%	10%	1%	*	71
	1994-95	39%	51%	10%	0%	45%	25%	8%	5%	17%	*	77
	1996-97	28%	51%	23%	0%	30%	39%	10%	5%	16%	*	80
	1998-99	18%	57%	21%	4%	22%	30%	4%	11%	29%	4%	54
	2000-01	20%	44%	32%	4%	29%	25%	9%	8%	29%	0%	70

Note: Until 1992-93 information was collected only for the total number of individuals receiving credit for all types of self-study.

\* Until 1998-99 the highest category for number of individuals receiving credit was >1,000, combining 1,000 to 10,000 and >10,000.

TABLE 9. Distribution of Medical Schools on Annual Number of CME Activities Oriented Primarily to Internal Physicians

		0	1-10	11-25	26-75	76-150	>150	50 <sup>th</sup> Percentile	Total Schools
Series/multiple activities (e.g., grand rounds) for credit	1996-97	1%	11%	25%	35%	20%	8%	35	76
	1998-99	5%	18%	24%	33%	12%	8%	30	60
	2000-01	3%	12%	20%	43%	16%	6%	38	68
Single occasion activities for credit	1996-97	52%	29%	8%	8%	1%	2%	0	77
	1998-99	33%	41%	12%	10%	2%	2%	2	49
	2000-01	36%	46%	9%	6%	0%	3%	2	66
Activities without credit, but with "paperwork" could have credit	1996-97	24%	36%	22%	13%	5%	0%	1-10	76
	1998-99	14%	49%	17%	13%	7%	0%	1-10	56
	2000-01	23%	42%	23%	9%	3%	0%	1-10	66

TABLE 10. Distribution of Medical Schools on Trend in Number of Regularly Scheduled Conferences Designated for Credit

Year (Reported in February)	Current Trend Is:					Mean [1-5]	Total Schools	
	Decreasing A Lot [1]	Decreasing A Little [2]	No Change [3]	Increasing A Little [4]	Increasing A Lot [5]			
Number of regularly scheduled conferences (e.g., grand rounds) designated for credit	2002	1%	6%	44%	33%	16%	3.6	73

The survey asked about CME activities oriented primarily to "internal" physicians, i.e. physicians who are faculty of the medical school. The questions and results are summarized in Table 9.

Virtually all schools designate credit for ongoing multiple session internal activities like grand rounds. However, schools vary widely on the number of these activities. Across the four years the 50<sup>th</sup> percentile is relatively stable ranging from 30 to 38 multiple session activities, with a slight shift upward over the past two years. The increase is consistent with the average report that the number of regularly scheduled conferences designated for credit is "increasing a little" – see Table 10.

Regarding single occasion internal activities for credit, Table 9 shows that approximately one-third of the schools indicated "none," with a 50<sup>th</sup> percentile value of 2. For some schools the answer may be somewhat misleading. If external physicians are also invited and a few attend, some schools may have included this type of activity in the counts of externally oriented courses included in Tables 4 and 5.

To assess the extent to which there are internal CME activities that are not receiving credit, the survey asked: "How many

CME activities were held for which credit was not designated, but could probably have had credit if the 'paper work' requirements (documentation of planning, attendance, evaluation) had been performed?". The responses are in the last section of Table 9. The typical response is that few additional meetings could receive credit – the 50<sup>th</sup> percentile is in the range of 1-10 activities across all three years.

## Course Fees

The questionnaire asked for the usual fee per credit hour for courses without unusual outside financial support, separating courses at the primary (home location) from courses at "pleasure" locations. The distribution of responses is presented in Table 11. As in past reports, the fee per credit hour varies greatly across schools.

The extent of change in course fees across the past years is indicated in Table 12. The table presents the 25<sup>th</sup>, 50<sup>th</sup>, and 75<sup>th</sup> percentiles for fees per credit hour from the current and past surveys. The top half of the table shows that for courses at the institution's primary location, the fees in 2002 have

TABLE 11. Distribution of Medical Schools on Usual Fee Per Credit Hour

Usual Fee per Credit Hour	Distribution for Courses At:	
	Primary Location	"Pleasure" Locations
\$0	2	4
\$1 to \$6	1	1
\$7 to \$9	2	0
\$10 to \$12	6	0
\$13 to \$15	16	3
\$16 to \$18	5	0
\$19 to \$21	13	8
\$22 to \$24	2	5
\$25 to \$27	7	13
\$28 to \$30	6	6
\$31 to \$35	0	7
\$36 to \$40	0	6
\$41 to \$50	1	3
\$50 or more	0	1
Total Schools	61	57

TABLE 12. Distribution (Quartiles) of Medical Schools on Usual Fee Per Credit Hour Across Biennial Surveys

	Reporting Year	Usual Fee Per Credit Hour			Total Schools
		25th Percentile	50th Percentile	75th Percentile	
Courses at Primary Location:	1986	\$10	\$12	\$15	51
	1988	\$10	\$15	\$17	54
	1990	\$10	\$15	\$18	70
	1992	\$12	\$15	\$20	62
	1994	\$10	\$15	\$20	72
	1996	\$12	\$15	\$20	79
	1998	\$12	\$15	\$20	75
	2000	\$12	\$16	\$23	58
	2002	\$13	\$18	\$23	61
Courses at "Pleasure" Location:	1986	\$14	\$16	\$20	45
	1988	\$15	\$20	\$22	46
	1990	\$16	\$20	\$25	57
	1992	\$18	\$21	\$25	48
	1994	\$15	\$23	\$28	64
	1996	\$18	\$23	\$28	64
	1998	\$18	\$25	\$30	67
	2000	\$20	\$25	\$32	50
	2002	\$20	\$25	\$33	57

TABLE 13. Distribution of Medical Schools on Usual Honorarium Arrangements for Faculty of the Medical School Speaking at the Medical School's CME Courses

Program Location	No Honorarium	Some-times (50th Percentile)	Usually (50th Percentile)	"Spouse's" Expenses	Total Schools
School's Primary Location					
1986	70%	13% (\$100)	17% (\$100)	NA	60
1990	66%	20% (\$150)	14% (\$100)	NA	64
1994	57%	22% (\$400)	21% (\$250)	NA	73
1998	58%	22% (\$350)	20% (\$250)	NA	76
2002	63%	25% (\$500)	12% (\$250)	NA	72
"Pleasure" Locations*					
1986	62%	4% (\$100)	24% (\$100)	10%	50
1990	67%	12% (\$200)	14% (\$200)	7%	58
1994	58%	17% (\$500)	24% (\$400)	1%	71
1998	60%	12% (\$450)	26% (\$500)	2%	69
2002	55%	7% (\$500)	33% (\$850)	5%	61

\*Travel and lodging expenses for the speaker are usually paid.

increased by approximately \$1 to \$2 per credit hour since 2000. The fees were relatively stable from 1992 until 2000.

The lower half of Table 12 shows that the fee per credit hour for courses at "pleasure" locations has tended to increase somewhat across the years. The fees for 2002 appear to be about the same as two years ago.

## Faculty Honoraria

**Local faculty.** The respondents were asked to indicate the usual honorarium arrangements for speakers at typical physician oriented courses, conferences, and seminars. The responses for honoraria payments to local faculty are summarized in Table 13.

The top half of Table 13 presents the results concerning courses at the school's primary location. For courses "at home," the majority (63%) of medical schools pay no honorarium. Another 25% of the schools pay an honorarium "sometimes", typically when course income is sufficient to make payments. For schools paying honoraria "sometimes", the honorarium, when paid, ranged from \$100 to \$1,250, with a median of \$500 (shown in parentheses in Table 13). The most frequent reasons for sometimes making these relatively high internal payments are "when there is commercial support" (4 responses) and "when course income can support it" (3 responses). The remaining 12% of schools usually pay an honorarium to local faculty. The usual payment ranges from \$100 to \$1,000, with a median of \$250.

Compared to previous years, the proportions paying no honoraria, honoraria sometimes, and honoraria usually have remained generally stable since 1990. When payments are made "sometimes", the amount of payment has increased somewhat over the years. The pattern for payments made "usually" has not changed appreciably.

The lower half of Table 13 presents the results for honoraria payments associated with courses held at "pleasure locations" away from the local area. Somewhat fewer institutions responded concerning honoraria for courses at "pleasure locations," presumably because some CME units do not offer courses at such locations.

The majority of schools (55%) do not pay an honorarium or remuneration other than travel and lodging expenses. Across the years the proportions have not changed appreciably for schools paying no honorarium, sometimes an honorarium, and usually an honorarium. When honoraria are paid "sometimes," the amount ranges from \$100 to \$1,500, with a median of \$500. The most frequently given reason for making the payment "sometimes" is "when commercial support is available" (3 responses). When honoraria are paid "usually," the amount ranges from \$250 to \$2,000, with a median of \$850. Across the years the size of honoraria has increased as shown in Table 14. Instead of an honorarium, a few schools pay for the travel expenses of a spouse to accompany the faculty member to "pleasure" locations. The number of schools paying for expenses of spouses is low, presumably because these payments are likely to be taxable as additional income under Internal Revenue Service regulations.

TABLE 14. Distribution of Medical Schools on Usual Honorarium Paid to Guest Faculty at the Medical School's CME Courses

Year	Honorarium Amount										"Spouse's" Expenses	Total Schools
	\$0-\$200	\$301-\$400	\$401-\$600	\$601-\$800	\$801-\$1,000	\$1,001-\$1,200	\$1,201-\$1,400	\$1,401-\$1,600	\$1,601-\$3,000	50 <sup>th</sup> Percentile		
School's Primary Location												
1986	34%	45%	17%	2%	2%	0%	0%	0%	0%	\$300	NA	58
1990	5%	46%	35%	14%	0%	0%	0%	0%	0%	\$400	NA	63
1994	5%	33%	24%	27%	17%	0%	3%	1%	0%	\$500	NA	69
1998	0%	8%	19%	32%	32%	1%	4%	3%	1%	\$750	NA	76
2002	3%	2%	13%	14%	39%	2%	11%	13%	3%	\$1,000	NA	68
"Pleasure" Locations												
1986	29%	28%	27%	2%	4%	0%	0%	0%	0%	\$350	10%	43
1990	9%	27%	32%	13%	11%	2%	0%	0%	0%	\$500	6%	47
1994	3%	32%	25%	26%	20%	0%	3%	0%	0%	\$625	2%	59
1998	0%	18%	20%	33%	30%	2%	0%	9%	0%	\$750	1%	67
2002	6%	2%	11%	11%	39%	0%	9%	11%	11%	\$1,000	3%	54

Note: Travel and lodging are also paid.

**Guest faculty.** The survey also asked usual honoraria arrangements and amounts for guest faculty at typical physician oriented courses, conferences, and seminars. An honorarium is virtually always paid to guest faculty. However, medical schools vary widely on the typical honorarium amount paid to guest faculty.

The top half of Table 14 presents the results for the school's primary location. The median payment is \$1,000. The median payment has increased across the time periods, with the largest increase occurring most recently, from \$750 to \$1,000 from 1998 to 2002.

The lower half of Table 14 presents the results for courses at "pleasure locations." The median amount is \$1,000. Across years the median payments at "pleasure locations" have paralleled payments at the school's primary location.

### Characteristics and Salaries of "Directors of CME"

While the Society membership is composed of a variety of individuals related to CME units in medical schools, the core of the membership are the "medical school directors of CME." A section of the survey attempted to characterize this group. Also, the Association of American Medical Colleges regularly collects data of salaries of medical school faculty and these data are regularly published in aggregate form to provide

norms for review. These data are not routinely collected for directors of CME units in medical schools. An additional objective of this section was to collect and make these data available. These data have been collected every four years since 1990.

The first step was to identify who is the director of CME at an institution. The answer is fairly clear at many institutions. But at several institutions more than one person shares part of the responsibility for the CME program and more than one level of responsibility is designated. Therefore the survey included a functional description of the role of the CME director to help institutions be consistent in identifying the person to whom the questions would apply. The description and relevant instructions are quoted below.

"The Director of CME is directly responsible for the day-to-day administration, supervision, and coordination of the CME unit and CME offerings for the medical school. The role usually involves a substantial portion (if not all) of the Director's professional time. The Director should not be confused with a Director's supervisor, usually an Assistant or Associate Dean who is responsible for broad oversight of a number of functional areas in addition to CME and devotes (or purports to devote) a small percentage of time to CME concerns. Also, the Director should not be confused with someone (usually supervised by a Director) who may be responsible for production of specific CME activities, but who is not responsible for overall

TABLE 15. Distribution of Medical Schools on Educational Training of "Director of CME"

Educational Training	1990		1994		1998		2002	
	N	%	N	%	N	%	N	%
High School	0	0%	6	8%	7	9%	5	7%
Bachelor	6	9%	7	10%	6	7%	2	3%
Master	15	23%	21	29%	30	37%	33	46%
Doctorate	18	27%	23	31%	24	30%	19	27%
Physician	27	41%	16	22%	14	17%	12	17%
All Levels	66	100%	73	100%	81	100%	71	100%

direction of the collection of CME activities of the medical school. (If you are still unsure, the Director is typically the person who attends the reaccreditation reverse site visit with the ACCME and both understands the questions the reviewers ask and can answer them correctly.)

"After considering the above attempt to identify the person who fulfills the role of 'Director,' a few institutions may conclude that the role is not performed by one clearly identifiable individual at your medical school - - at least in so far as being a major determinant of one individual's salary is concerned. For example, the CME structure may be sufficiently decentralized that the functional role is distributed across a variety of people or the CME activities may be so few that the role is not a major portion of anyone's activity. If no one individual can be identified, please write a short explanation of your situation and go on to the next section. Everyone else, please tell us about your 'Director'."

**Characteristics of the "Director."** The survey included eight questions about characteristics of the "Director" and the "Director's" job. Four questions concerned the personal background of the "Director": educational training, gender, total years of work experience, and years of work experience in CME. Three questions concerned job characteristics: the actual job title, whether being "Director" was the person's primary work responsibility, and the percent time the person allocated to being "Director". One question concerned the CME unit: the number of staff in the unit. (Data on annual number of CME courses and attendance were also available in the survey.) One item concerned regional variation in salaries: how salaries in that medical school compared with those in other geographic areas.

Distributions on each characteristic were examined as well as associations across characteristics. Several characteristics were associated, with the measure of educational training having the strongest relationships with other variables. For this reason the data concerning other characteristics will be presented by educational training level. Differences associated with educational level were also found in the previous years. Data in those reports were also presented by educational training level.

The information concerning educational training is presented in Table 15. Individuals at all levels of training were identified as "Directors," with the majority having master's degrees. The major shifts across time are the reduction in the number of physicians from 41% to 17% and the increase in the number with master's degrees from 23% to 46%. These shifts probably reflect the increase in day-to-day administrative responsibilities associated with both the increased number of CME activities (compare 1988-89 to 2000-01 in Table 5) and increases in administrative and documentation work associated with individual courses.

The distributions for eight other characteristics of "Directors of CME" are presented in Table 16.

Section (a) of Table 16 presents the distribution on gender. While 66% of the "Directors of CME" are women, the distribution differs appreciably by level of education. Women tend to predominate among individuals with formal education at the high school, bachelors, and masters levels. Men predominate among those with doctoral or medical degrees. This pattern has appeared in previous years, although the proportion of women at the doctoral and physician levels is increasing.

Section (b) presents the distribution on years of work experience by educational training across all individuals. Across all individuals the mean is 25 years of work experience, similar to the findings in previous years. Across educational levels the means range from 26 to 29 years for all levels except physicians, who average 23 years. This is a shift from past years, when physicians had the most years of work experience.

Section (c) presents the distributions on years of CME experience. Across all levels of training the mean is 13 years of CME experience, similar to the findings in 1998 and somewhat more than the 10 years of CME experience that was found in both 1994 and 1990. The means range from 11 to 14 years within educational levels, except for those with bachelor's degrees having a mean of 18 years.

TABLE 16. Distribution of Medical Schools on Characteristics of "Director of CME" by Educational Training

	<u>(a) Gender of "Director of CME"</u>		Total Schools	<u>(b) Years of Work Experience</u>				Total Schools
	Male	Female		1-5	6-10	11-30	31-50	
High School	0	5	5	0	0	5	0	5
Bachelor	1	1	2	0	0	2	0	2
Master	4	28	32	0	1	25	6	32
Doctorate	12	7	19	1	0	10	7	18
Physician	7	5	12	1	0	8	2	11
All Levels	24	46	70	2	1	50	15	68

  

	<u>(c) Years of CME Work Experience</u>				Total Schools	<u>(d) Actual Title of "Director of CME"</u>			Total Schools
	1-5	6-10	11-20	21-30		Coordinator	Director	Assistant or Assoc. Dean	
High School	1	1	3	0	5	3	2	0	5
Bachelor	0	0	1	1	2	0	2	0	2
Master	8	8	10	6	32	4	25	3	32
Doctorate	4	3	7	3	17	0	8	9	17
Physician	1	7	2	1	11	0	3	8	11
All Levels	14	19	23	11	67	7	40	20	67

  

	<u>(e) Is Primary Work Responsibility "Director of CME"?</u>		Total Schools	<u>(f) Percent Time Spent on "Director of CME"</u>					Total Schools
	No	Yes		1%-20%	21%-40%	41%-60%	61%-80%	81%-100%	
High School	0	5	5	0	0	1	0	4	5
Bachelor	0	2	2	0	0	0	0	2	2
Master	2	31	33	0	0	1	0	32	33
Doctorate	2	17	19	0	0	2	4	13	19
Physician	7	5	12	0	6	4	1	1	12
All Levels	11	60	71	0	6	8	5	52	71

  

	<u>(g) Number of Staff in the CME Unit</u>					Total Schools	<u>(h) Salaries Compared to Those in Other Regions</u>					Total Schools
	1-3	4-6	7-9	10-19	20-30		Very Low	Somewhat Low	About Average	Somewhat High	Very High	
High School	2	1	1	1	0	5	1	0	1	1	0	3
Bachelor	0	1	0	1	0	2	0	0	1	0	0	1
Master	10	13	7	2	1	33	0	12	11	2	0	25
Doctorate	3	5	2	6	3	19	0	7	10	1	1	19
Physician	3	2	0	5	2	12	1	4	4	2	0	11
All Levels	18	22	10	15	6	71	2	23	27	6	1	59

Section (d) presents the actual title of the person identified as the "Director of CME." Most of the titles were classifiable as either a Coordinator of CME, a Director of CME, or an Assistant or Associate Dean for CME. A few titles were not easily classified and were omitted from this analysis. Individuals with high school or bachelor's degrees are coordinators or directors. Individuals with master's degrees are usually directors. Individuals with doctoral degrees are usually directors or deans. Physicians are usually deans. This same

general pattern of association between education level and job title has been found in previous years.

Another job characteristic is the extent to which the individual's primary work responsibility is "Director of CME." The responses to this item are presented in section (e) of Table 16. Across all individuals 85% have this assignment as their primary responsibility, almost identical to the findings since 1994. Most non-physicians have been "Director of CME" as

their primary responsibility. The majority of physicians are likely not to have CME as their primary responsibility. This pattern was similar in previous years.

A closely related characteristic is the percent of the person's time allocated to being "Director." The distributions are presented in section (f) of Table 16. As expected, the results closely parallel those in the preceding paragraph regarding primary work responsibility. Across all individuals the mean is 87% of the time, up from 67% in 1990, 79% in 1994, and 82% in 1998. The means are above 90% for all education levels except physicians, who average 48% of their time being "Director." This pattern is generally consistent with past years, except the time of individuals with doctoral degrees has increased from the 80% level typically seen in past years.

A characteristic of the "Director's" CME unit is the number of staff in it. The distributions on this characteristic are presented in section (g) of Table 16. Across all individuals the range is from 1 to 39 staff members, with a mean of 8.0. This continues incremental increases over the years, with mean number of staff members being 5.0, 5.5, and 6.2 in 1990, 1994, and 1998, respectively. The size of staff tends to be associated with education level: individuals without a doctoral degree oversee units averaging 5 to 8 staff while individuals with doctoral or medical degrees oversee units averaging 11 to 12 staff. In contrast, differences in staff size were not associated with level of educational training in previous years.

The final characteristic concerns general differences in medical school salaries by geographic area. The distribution of responses comparing perceptions of those at the "Director's" medical school with those in other areas are presented in section (h) of Table 16. Across all individuals 84% responded either "somewhat low" or "about average". These results are very similar to those found previously. At all time periods the distributions does not differ by educational training of the "Director." (It appears that almost no one feels that their medical school's salaries are above average.)

**Salary of the "Director."** Two items were asked about remuneration: the annual full time salary of the "Director" and whether the "Director" could earn significant extra income through a bonus or a medical practice plan.

The range of salary levels is presented in Table 17. Looking at the 50<sup>th</sup> percentiles, the systematic difference in salary by education level is evident. Looking within education level, all of the median salaries had increases in the last four years, ranging from \$10,000 to \$25,000.

The footnote to the table points out that the amount of missing data can be higher for salary than for many other items in the survey. As shown in the last column, until this year the missing data were primarily for physicians. These omissions may not have serious practical implications. Section (e) in Table 16 showed that being "Director of CME" was the primary work responsibility of fewer than half of the physicians. Their salaries are more likely to be determined by

job characteristics other than those associated with their CME responsibilities. The results for physicians can be viewed as only a general indication concerning salary.

For all of the educational training categories a related cautionary statement should be made. The sample sizes are small and the results provide only a general indication of salaries and ranges and of factors related to salaries.

It was noted above that educational training was the characteristic most strongly associated with the salary of the "Director." Educational training by itself accounts for 57% of the variance in salaries, with the physician component of education level accounting for much of this variance. A stepwise multiple regression was performed that included all of the characteristics as predictors of salary to see if other predictors could account for significant additional variance in salary. The other statistically significant predictors are a negative relationship with percent time being Director (6% additional variance) and a positive relationship with job title (3% additional variance). These variables together account for 67% of the variation in salaries ( $n = 61$ ,  $p < .0001$ ). These relationships are similar to those found in past years.

The specific variables identified in the preceding stepwise regression analysis may obscure associations with related variables. When predictors are associated (i.e. confounded) with each other, the stronger predictor accounts for most of their shared relationship to the dependent variable. Several of the predictors were associated with each other: education level, job title, percent time being "Director of CME," gender, and primary work responsibility. Therefore, the preceding analyses simply to suggest factors most strongly associated with salary in this sample.

The final information about salary concerns the potential for income beyond salary. The distribution on this aspect of salary is presented in Table 18 by educational training. This possibility occurs for approximately 16% of those with doctoral degrees and 36% of physicians. This result is consistent with reports in previous years. It should be noted that physicians typically also have clinical responsibilities and may share in surplus clinical revenue.

## CME Reporting Structure

CME units have a variety of "upward" reporting structures that may involve various levels in a medical school, in hospital administration, and in academic health center units comprised of several colleges for various health professions. The survey listed a variety of titles likely to be involved in the reporting structure. Respondents were asked to put the number "1" by the title of the person formally in charge of the CME unit, then put number "2" by the title of the person to whom number "1" reports, and continue numbering the "upward" reporting structure in sequence. As expected, a variety of

TABLE 17. Range of Salary of "Director of CME"  
by "Director's" Education Training

Educational Training of "Director"	Year	Salary					Data for this number of "Directors" <sup>a</sup>
		Min-imum	25th Percentile	50th Percentile	75th Percentile	Max-imum	
High School	1990	---	---	---	---	---	0
	1994	\$26,500	\$34,000	\$34,000	\$48,000	\$52,000	6 of 6
	1998	\$17,000	\$32,000	\$39,000	\$63,000	\$64,000	7 of 7
	2002	\$38,000	\$41,000	\$52,000	\$63,000	\$75,000	5 of 5
Bachelor	1990	\$25,000	\$29,000	\$40,000	\$46,000	\$53,000	5 of 6
	1994	\$30,000	\$32,000	\$38,000	\$59,000	\$80,000	7 of 7
	1998	\$27,000	\$35,000	\$62,000	\$67,000	\$68,000	4 of 6
	2002	\$50,000	--	--	--	\$95,000	2 of 2
Master	1990	\$20,000	\$33,000	\$38,000	\$48,000	\$60,000	14 of 15
	1994	\$28,000	\$43,000	\$50,000	\$58,000	\$84,000	19 of 21
	1998	\$38,000	\$48,000	\$55,000	\$60,000	\$83,000	28 of 30
	2002	\$39,000	\$56,000	\$65,000	\$74,000	\$104,000	33 of 33
Doctorate	1990	\$23,000	\$45,000	\$56,000	\$65,000	\$83,000	15 of 18
	1994	\$40,000	\$54,000	\$63,000	\$75,000	\$106,000	21 of 23
	1998	\$46,000	\$60,000	\$78,000	\$100,000	\$140,000	22 of 24
	2002	\$51,000	\$70,000	\$100,000	\$123,000	\$135,000	19 of 19
Physician	1990	\$53,000	\$95,000	\$104,000	\$127,000	\$155,000	12 of 27
	1994	\$83,000	\$100,000	\$117,000	\$150,000	\$175,000	9 of 15
	1998	\$64,000	\$120,000	\$150,000	\$154,000	\$195,000	9 of 14
	2002	\$72,000	\$121,000	\$175,000	\$195,000	\$280,000	10 of 12

<sup>a</sup> The subset of institutions providing salary information of the number indicating the "Director's" educational training is: 1990, 46 of 66; 1994, 62 of 73; 1998, 70 of 81; 2002, 69 of 71.

TABLE 18. Distribution of "Director's of CME" on Possibility of Income beyond Salary  
by "Director's" Educational Training

Educational Training of "Director"	Possibility of Income Beyond Salary			Data for this number of "Directors" <sup>a</sup>
	None	Up to 25% of Salary	Over 25% of Salary	
High School	5	0	0	5 of 5
Bachelor	2	0	0	2 of 2
Master	31	0	0	31 of 33
Doctorate	16	3	0	19 of 19
Physician	7	2	2	11 of 13

<sup>a</sup> The subset of institutions providing salary information of the number indicating the "Director's" educational training is 68 of 71.

TABLE 19. Distribution of Medical Schools on Title of Person in Charge of CME Unit and Reporting Levels Up to the Dean

Title of Person in Charge of CME Unit	Not Up to Dean	Levels Up to Dean (% with title)			No. of Schools (% of Schools)	
		3	2	1		
CME Coordinator	0%	50%	50%	0%	4	6%
CME Director	12%	12%	68%	8%	40	56%
Department Chair	0%	0%	0%	100%	1	1%
Assistant Dean for CME	0%	17%	66%	17%	6	8%
Associate Dean for CME	0%	0%	20%	80%	10	14%
Associate Dean (other)	0%	0%	33%	67%	6	8%
Senior Associate Dean	0%	0%	0%	100%	1	1%
A Senior Academic Health Center Administrator	100%	0%	0%	0%	3	4%
Other above Medical School	100%	0%	0%	0%	1	1%
All titles combined	14%	13%	51%	22%	72	100%

TABLE 20. Distribution of Medical Schools on Titles of Individuals in Upward CME Reporting Structure (N = 72 Medical Schools)

Title	In Reporting Structure	Title (continued)	In Reporting Structure
CME Coordinator	6%	A Senior Hospital Administrator	3%
CME Director	60%	Head of Hospital	4%
Department Chair	3%	A Senior Academic Health Center Administrator	8%
Assistant Dean for CME	18%	Head of Academic Health Center	20%
Assistant Dean (other)	1%	A Senior University Administrator	7%
Associate Dean for CME	39%	Head of University	42%
Associate Dean (other)	22%	Other above Medical School	15%
Senior Associate Dean	22%		
Other within Medical School	5%		
Dean	86%		

specific reporting sequences were reported. However, some general patterns were evident that can be easily summarized.

The rows of Table 19 list the titles of individuals formally in charge of the CME unit (i.e. noted as number "1" in the reporting structure). For example CME Coordinators were listed as in charge at 4 (6%) of the schools. Then the reporting relationships were examined to determine whether they went through the Dean of the medical school and, if so, the number of levels up between the person in charge of the CME unit and the Dean. As shown in Table 19, none of the CME Coordinators have reporting structures that do not include the dean of the medical school. Half of the CME Coordinators have three reporting levels to the Dean (i.e. they report to someone who reports to someone else who reports to the Dean), half have two reporting levels, and none report directly to the Dean (i.e. one reporting level).

Across CME units 14% have reporting structures that do not include the Dean of the medical school. Some of these units are organizationally located in the main teaching hospital and

report through that structure. Others are located in institutional structures that are organizationally above the medical school, e.g., a unit in an academic medical center that supports continuing education activities of several colleges of health professions such as medicine, nursing, and dentistry.

For the 86% of CME units that report to the Dean of the medical school, a pattern is evident between the title of the person in charge of the CME unit and the number of reporting levels to the Dean. Coordinators tend to have three or two reporting levels up. Directors and Assistant Deans tend to have two. Department Chairs, Associate Deans, and Senior Associate Deans tend to report directly to the Dean.

Table 20 lists the frequency with which each title was listed in the overall upward CME reporting structure, starting with the person in charge of the CME unit. It provides a sense of the titles involved in the upward reporting structures within medical schools (left half) and the reporting structures at hospitals and in organizational units above the medical school (right half). Examples of some of the "other" titles within the

medical school include "Vice Dean" and "Executive Assistant to the Dean." Examples of "other" titles outside of the medical school include "Chancellor," "Assistant Vice President for Continuing Education," and "Senior Vice President and Provost.

The surveys in 1986 and 1998 made a more limited inquiry into the CME reporting structure. Those surveys simply asked respondents to identify the individual (by title) to whom the person in charge of the CME unit reported. The results in this survey were generally similar to the previous reports (e.g., in 1998 87% of the units reported to individuals within the medical school, including the Dean).

### CME Unit Financing

One of the more complex and confusing issues across medical school CME units is how they are financed. Institutions vary widely in the economic context and assumptions about CME activities and CME units. For example, a CME unit may be in a highly rated medical school and located in a major metropolitan area that is also a highly rated destination city. In this situation CME activities are likely to generate substantial revenue and this revenue will be used to pay for out-of-pocket course expenses, the operation of the CME unit, indirect costs for supporting services of the university, and other overhead and indirect expenses. In contrast, a CME unit may be in a small medical school located in a fairly sparsely settled area where most of the local community physicians have clinical appointments and attend courses without charge. In this situation CME activities are likely only to generate revenue sufficient to cover out-of-pocket expenses of the activity and the institution may pay for the CME unit and all indirect and overhead costs. Another important factor is whether CME activity production is centralized in the CME unit or decentralized to individual departments. The extent of centralized production can affect the charge structure for producing courses. In a decentralized system much of the revenue and expenses associated with CME activities may go through departmental accounts rather than the CME unit. The extent of centralized control of CME activities can also affect the extent to which the CME unit or the content department assumes risk for financial deficits or potentially benefits from financial surpluses.

The survey asked several questions about CME unit finances: CME unit revenue and expenses, the extent of internal subsidization, financial arrangements for individual courses, payments (revenue "taxes") to the institution and state, and the handling of annual net deficits and surpluses of the CME unit. Similar questions were asked in 1994 and this survey provides comparisons across the eight year period. This descriptive report presents information about each of these areas separately. To understand the financing arrangements for a CME unit at a specific institution, these characteristics, underlying factors, and their interrelationships at the institution would have to be jointly considered in what would effectively be a case study.

**CME unit revenue and expenses.** For the last fiscal year, CME units were asked how much revenue the unit received from specified sources and how much the CME unit's expenses were. The distribution of responses (in thousands of dollars) is presented in Table 21. The upper portion of the table shows the amount of revenue from sources external and internal to the institution. Almost all CME units receive course fees and funds from commercial companies. Those are the main two revenue sources, with a median of \$484,000 in registration fees and a median of \$534,000 in commercial support and exhibit fees. The medical school provides funds to 60% of CME units, with a median of \$45,000. Other sources of revenue do not occur at the substantial majority of medical schools. However, at a few schools other sources may provide substantial revenue.

Looking at the differences in revenue across the eight years from 1994 to 2002, three trends are noteworthy. The amount of commercial support has increased five-fold and is now the largest source of revenue across most medical schools. Revenue from registration fees has doubled and dropped from being the most important source of revenue to being a close second. The percent of schools directly receiving funds from the medical school dropped from 74% to 60% and the amount of funding from medical schools has not increased appreciably over the eight years.

The last three lines of Table 23 summarize the overall revenue, expenses, and net balance for CME units. The tremendous range is evident. Specific interpretations must be made with some caution because only the revenue and expenses handled by the CME unit are included. At some schools course revenue and expenses may be handled through departmental accounts rather than the CME unit. Also, as is shown in the next section, some institutions subsidize the CME unit without including these expenses in the financial accounts for the CME unit. The reported data show that CME units have median revenues of approximately \$1,500,000, median expenses of approximately \$1,300,000, and median a net balance of \$30,000, i.e. 2% of gross revenue. (Note: Medians are not additive since different schools may have the median amount on different measures.)

Looking at the difference in total revenue, total expense, and net balance for 1994 and 2002, they have all more than doubled. However, the proportions have remained about the same. In both 1994 and 2002 the net balance is 2% of the gross income. [Editorial note: These results are consistent with the ACCME data for all nationally accredited providers for 2000. ACCME data show that the mean net surplus for the 118 CME accredited medical schools in the U.S. is 3%. In contrast, the mean net surplus for all 680 nationally accredited CME providers is 21%.]

**Subsidization by internal sources.** Other parts of the CME unit's institution (e.g., medical school, hospital, practice plan, university) may underwrite the CME unit's expenses.

TABLE 21. Distribution of Medical Schools on the CME Unit's Annual Revenue (by source), Expenses, and Balance (in thousands of dollars)

	Year	Percent with \$0 or Minimum \$	25th Percentile	50th Percentile	75th Percentile	99th Percentile*	Total Schools
<b>Revenue from:</b>							
<u>External Sources:</u>							
Registration Fees & Misc.	1994	1%	\$89	\$225	\$541	\$1,798	73
	2002	7%	\$124	\$484	\$1,098	\$5,715	68
Commercial Support & Exhibit Fees	1994	5%	\$20	\$106	\$260	\$1,723	72
	2002	\$6	\$165	\$534	\$1,384	\$4,377	67
Enduring Materials	1994	78%	\$0	\$0	\$0	\$60	70
	2002	73%	\$0	\$0	\$6	\$150	67
State Gvmt./Public Sources	1994	69%	\$0	\$0	\$8	\$227	74
	2002	85%	\$0	\$0	\$0	\$150	67
Educational Research	1994	94%	\$0	\$0	\$0	\$70	74
	2002	96%	\$0	\$0	\$0	\$16	67
Gifts and Other Grants	1994	78%	\$0	\$0	\$0	\$41	69
	2002	81%	\$0	\$0	\$0	\$100	67
Other Sources	1994	74%	\$0	\$0	\$1	\$214	68
	2002	69%	\$0	\$0	\$20	\$476	67
<u>Within the Institution:</u>							
Medical School	1994	26%	\$0	\$44	\$97	\$288	74
	2002	40%	\$0	\$45	\$128	\$368	68
Affiliated Hospitals	1994	60%	\$0	\$0	\$12	\$220	74
	2002	70%	\$0	\$0	\$0	\$269	68
Practice Plans	1994	82%	\$0	\$0	\$0	\$61	74
	2002	94%	\$0	\$0	\$0	\$329	67
Other Instnl. Sources	1994	68%	\$0	\$0	\$6	\$137	74
	2002	82%	\$0	\$0	\$0	\$585	67
<b>Total Revenue</b>	1994	\$7	\$283	\$642	\$1,042	\$2,233	68
	2002	\$215	\$658	\$1,474	\$2,815	\$15,411	68
<b>Total Expenses</b>	1994	\$10	\$253	\$540	\$923	\$2,183	69
	2002	\$125	\$529	\$1,278	\$2,813	\$13,471	67
<b>Net Bal. (Rev. - Expns.)</b>	1994	-\$200	\$0	\$11	\$56	\$405	66
	2002	-\$250	\$0	\$28	\$193	\$2,081	66

Note: The columns do not add because they are percentiles. Schools may rank differently on the measures down the columns.

\* In many instances the maximum value was an "outlier" far beyond the other values. For this reason the next-to-highest (99th percentile) value is reported rather than the maximum value.

When the expenses are paid using internal funds, the funds may be transferred to the CME unit, appearing as revenue and expenses in Table 21. Alternatively, internal sources may pay for expenses directly, with no revenue or expense appearing on the financial accounts of the CME unit.

Information was collected concerning internal support for five types of operating expenses. The left column in Table 22

indicates the five types of expenses. The left half of the table presents the distribution of medical schools on the percent of the expense that was paid by internal funds. At 50% to 67% of medical schools internal funds pay for 100% of the expenses for: the salaries of CME unit personnel, the CME unit's equipment, and meeting space at the institution for externally oriented courses. At more than 80% of medical schools

TABLE 22. Distribution of Medical Schools on  
 (a) the Percent of Selected CME Unit Expenses That Are Paid by Internal Institutional Funds  
 and (b) Whether the Internal Funds are Counted in the CME Unit's Finances

Type of Expense	Year	(a) % of Expense Paid by Internal \$					Total Schools	(b) Intrnl. \$ in Unit's Finances?			Total Schools w Intl. \$
		0%	1%-20%	21%-80%	81%-99%	100%		No	Some	Yes	
CME Personnel Salary & FB	1994	18%	12%	26%	4%	40%	68	9%	4%	87%	45
	2002	9%	8%	26%	7%	50%	54	26%	2%	72%	43
CME Unit Equipment	1994	35%	4%	13%	3%	45%	65	19%	9%	72%	32
	2002	16%	4%	18%	2%	60%	45	25%	8%	67%	40
CME Unit Office Space	1994	12%	5%	4%	0%	79%	62	55%	2%	43%	44
	2002	5%	2%	6%	2%	85%	61	61%	2%	37%	46
Central Services: payroll, time keeping, etc	1994	17%	2%	3%	2%	76%	62	60%	5%	35%	40
	2000	6%	2%	5%	5%	82%	60	73%	2%	25%	48
Course Meeting Space	1994	39%	5%	7%	0%	49%	59	68%	4%	28%	28
	2002	16%	4%	9%	4%	67%	51	68%	7%	25%	44

internal funds pay for 100% of the expenses for: the office space of the CME unit and the central services (e.g., payroll, time keeping, personnel, purchasing) that the CME unit uses. From 1994 to 2002 the number of schools receiving internal funding for these costs increased by roughly 10%.

For the half or more of the CME units that are receiving internal funds for these various expenses, are these internal funds included in the finances of the CME unit reported in Table 21? This question is answered in the right half of Table 22. This section of the table concerns only those CME units receiving some internal funds for the specified expense. The majority (72%) of the CME units receiving internal funds for unit personnel are including all of these funds in the unit's finances. The majority (67%) include the institutional funds for unit equipment in their unit's finances. Only one-third to one-quarter include institutional funds for office space, central services, and course meeting space in the unit's finances. It appears that for the majority of CME units, some appreciable institutional support is not included in the report of the unit's revenue and expenses for Table 21. From 1994 to 2002 a slightly smaller number of schools included internal funds in reporting the unit's finances.

**Financial arrangements for individual courses.** Across CME units the financial arrangements for individual courses vary tremendously. CME units that are totally subsidized by the institution may retain no funds from CME courses. In producing CME courses the CME unit may charge a fixed fee per course, per course day, or per course registrant. Alternatively, the CME unit may retain ("charge") a percentage of the course's total revenue, of the course's expenses, or of each registration fee. The handling of net deficits and surpluses also varies greatly, from the CME unit being totally responsible, to the deficits and surpluses being split between

the CME unit and a cosponsoring clinical department, to the cosponsoring department being totally responsible. With different combinations of these arrangements in place at various medical schools, a description of financial arrangements for courses is necessarily oversimplified.

Table 23 describes five general types of financial arrangements for courses and the percentage of medical school CME units following each type. Currently the most frequent arrangement (68%) is for a production fee to be paid to the CME unit and the cosponsoring department to retain course deficits and surpluses. Although this was the most frequent arrangement in 1994 (38%), over the years the majority of CME units have shifted to this arrangement. These arrangements guarantee funding for the CME unit, removing both the risk of loss and the opportunity for profit that are included with other options.

For the 68% of schools that simply pay the CME unit a production fee (first row of Table 23), the survey asked for more detail about the production fee. At half of these schools the production fee is based on a standard schedule and at the other half the production fee is determined for each course. The specifics of schedules can vary widely, including being based on a fee per course day, a fee per course day plus a fee per registrant, or equal to a percentage (e.g., 20%) of the out-of-pocket course expense. These schools were asked what typical production fees are for mostly lecture courses ranging from 1/2 day to three days. The results are presented in Table 24. The fees range very widely across schools, probably due to differences in institutional revenue provided to the unit and in expenses for which the unit is responsible (see above). The median typical fees by course length are: 1/2 day, \$1,500; 1 day, \$3,000; 2 days, 4,000; and 3 days, \$5,500. Across eight years from 1994 to 2002 the fees have approximately doubled.

TABLE 23. Distribution of Medical Schools on General Funding Arrangements for Individual Courses

Allocation Arrangement for Course Deficits and Surpluses	Percent of Medical Schools in:	
	1994	2002
Go to cosponsoring department, with a production fee paid to the CME unit	38%	68%
Split between CME unit and cosponsoring department. (CME unit may also charge a production fee.)	28%	16%
Go to cosponsoring department, with a percentage of the course revenue retained by the CME unit	11%	7%
Remain with CME unit	10%	4%
Other allocation arrangements	13%	4%
TOTAL SCHOOLS	71	69

TABLE 24. Distribution of Medical Schools on the Typical Production Fee Charged by the CME Unit, for Schools with CME Units That Charge a Production Fee

Course Length	Year	Minimum	25th Percentile	50th Percentile	75th Percentile	Maximum	Total Schools	
One-half Day	1994	(Data not collected)						
	2002	\$150	\$500	\$1,500	\$2,500	\$5,000	31	
One Day	1994	\$150	\$1,000	\$1,750	\$2,500	\$4,000	33	
	2002	\$750	\$1,400	\$3,000	\$6,000	\$12,000	32	
Two Days	1994	\$300	\$1,200	\$2,500	\$3,500	\$6,000	32	
	2002	\$1,000	\$2,500	\$4,000	8,000	\$12,000	31	
Three Days	1994	\$1,000	\$2,000	\$3,000	\$4,500	\$9,000	29	
	2002	\$1,000	\$2,500	\$5,500	\$9,500	\$18,000	29	

Note: These data are for schools where the CME unit charges a production fee and cosponsoring departments retain all course deficits and surpluses. Not included in either year two CME units that only charge a small processing fee (e.g., \$100) for all courses. The production fees have similar 25<sup>th</sup>, 50<sup>th</sup>, and 75<sup>th</sup> percentiles for 9 schools where the CME unit charges a production fee and shares course deficits and surpluses with the cosponsoring department.

TABLE 25. Distribution of Medical Schools on the Percentage of Course Deficits and Surpluses Going to the CME Unit, for Schools that Split Them between the CME Unit and the Cosponsoring Department

	Year	Percentage Going to the CME Unit							Total Schools
		0%	1-20%	21-40%	41-60%	61-80%	81-99%	100%	
Course Deficit	1994	36%	7%	14%	36%	0%	0%	7%	14
	2002	20%	10%	10%	50%	0%	0%	10%	10
Course Surplus	1994	0%	7%	43%	43%	7%	0%	0%	14
	2002	0%	18%	18%	55%	9%	0%	0%	11

As shown in the second row of Table 25, 16% of CME units split deficits and surpluses with the cosponsoring department. The survey asked for more detail about financial arrangements at these 12 schools. At nine of these schools the production

work of the CME unit was included as a cost. For those nine schools questions were asked about production fees. The production fees at these schools were similar to those at schools that do not participate in course deficits and surpluses, which were discussed in the preceding paragraph. At four

TABLE 26. Distribution of Medical Schools on the Disposition of the CME Unit's Annual Net Financial Deficit or Surplus

	Year	Carried Forward to Next Year	Net Balance Transferred to the Institution	Other	Total Schools
Deficit	1994	41%	45%	14% <sup>a</sup>	71
	2002	47%	46%	7%	70
Surplus	1994	57%	36%	7% <sup>b</sup>	74
	2002	63%	32%	4%	71

<sup>a</sup> For a deficit, most of the "other" responses were "Have not had a deficit" or "Fully funded, can't have a deficit."

<sup>b</sup> For a surplus, most of the "other" responses were "Have not had a surplus" or "Fully funded, can't have surplus."

schools the production fee is based on a standard schedule and at five schools the fee is determined for each course. At the nine schools the typical production fees for mostly lecture courses of varying length have approximately the same 25<sup>th</sup>, 50<sup>th</sup>, and 75<sup>th</sup> percentiles as those shown in Table 24 (generally within \$500 to \$1,000). The survey asked all 12 schools about the percentage of deficits and of surpluses that were retained by the CME unit. The results are presented in Table 25. The most common arrangement is a 50% / 50% split of both deficits and surpluses. The percentage of deficits falling to the CME unit varies widely, from 0% to 100%. The percentage of surpluses retained by the CME unit ranges from 10% to 65%. Since 1994 the percentages have shifted somewhat more towards a 50% / 50% split.

The third line of Table 23 indicates that five CME units retain a percentage of the course revenue. The percent retained ranges from 10% to 20%, similar to the range of 5% to 15% found in 1994. A few of the schools also charge a fee per registrant that ranges from \$10 to \$45.

The fifth line of Table 23 notes that 4% of schools have "other" allocation arrangements. Some are combinations of various components of the activity, for example, the CME unit receives a credit designation fee (\$500 for internal activities and \$1,000 for external activities), \$25 per registrant, and 10% of commercial support, with the co-sponsoring department retaining deficits and surpluses. Another arrangement is having the fee based on the commercial support received.

**Other revenue sharing.** The CME units were asked if a percentage of the gross revenue usually went to a unit (medical school, university, or state) other than the CME unit or cosponsoring department. Of the 74 responding CME units, 82% did not share revenue with these types of other units. Of the 13 CME units sharing revenue, six give a percentage to the medical school (median 10%) and six give a percentage to the university (median 7.5%). No other sharing was noted. The sharing arrangements are similar to 1994 when 87% of CME units did not share revenue with these types of other units.

**CME unit annual deficit or surplus.** The last financial items concerned the disposition of the CME unit's net balance (deficit

or surplus) at the end of its fiscal year. The results are presented in Table 26. For an annual deficit, the responses split fairly evenly between carrying forward the deficit and transferring it to the institution. Most CME units responding in the "other" category were in the fortunate position of never having had a deficit and not knowing what would happen if one occurred. For an annual surplus, a somewhat larger number would retain and carry forward the surplus than would transfer it to the institution. Most responses in the "other" category were from institutions that have accounting arrangements that allocate revenue and expenses in ways that do not let the CME unit's accounts have a surplus. These results are very similar to those found in 1994.

### Some Fees Charged by the CME Unit

**Internal credit designation and transcript fees.** The survey updated information asked in 1996 about fees for some services provided by CME units. The services and results are presented in Table 27.

Table 27 is consistent with Table 9 in showing that most (96%) of schools designate credit for internal activities such as grand rounds. Table 27 additionally shows that 42% of schools charge a fee for credit designation. Most schools that charge have a fixed fee per activity, with a median fee of \$300. A few schools have fee schedules that vary with aspects of the activity including the number attending (\$400 for credit designation + \$7.50 per registrant for individual credit recording), number of sessions (\$195 for credit designation + \$35 per session), and number of hours (\$25/hour + \$1 per registrant). Both the number of schools charging a fee and the fee amount have doubled since 1996.

The majority (72%) of schools provide an annual internal transcript of CME credit to physicians internal to the institution. A minority (16%) of these schools charge a fee for the transcript. When charged, the median fee is \$25. These results are not greatly changed from reports in 1996.

TABLE 27. Distribution of Medical Schools on Some Internal Services and Fees of the CME Unit

	Year	Performed?			If Yes, Fee?			If Fee, the Usual Amount			N
		No	Yes	N	No	Yes	N	25th %tile	50th %tile	75th %tile	
Designate credit for internal activities (e.g., grand rounds)	1996	5%	95%	87	76%	24%	84	\$30	\$150	\$300	20
	2002	4%	96%	74	58%	42%	66	\$140	\$300	\$650 <sup>a</sup>	25
Provide an annual transcript of CME credit to physicians <u>internal</u> to your institution	1996	38%	62%	87	75%	25%	56	\$12	\$25	\$30	13
	2002	28%	72%	72	84%	16%	49	\$15	\$25	\$30	10
Provide an annual transcript of CME credit to physicians <u>external</u> to your institution	1996	55%	45%	87	55%	45%	39	\$10	\$20	\$30	19
	2002	48%	52%	74	62%	38%	37	\$15	\$25	\$30	19

<sup>a</sup> See text for description of fees that vary by factors that vary according to the specific activity.

TABLE 28. Distribution of Medical Schools on Credit Designation and Fees When Working with Communication Companies

	Year	Performed			If Fee, the Usual Fee			N
		No	Yes	N	25th %tile	50th %tile	75th %tile	
Designate credit for a “satellite symposium” held with a major society meeting?	2000	48%	52%	58	(not asked)			23
	2002	41%	59%	73	\$3,000	\$5,000	\$7,500 <sup>a</sup>	
Designate credit for an enduring material ?	2000 <sup>b</sup>	40%	60%	57	(not asked)			24
	2002	33%	67%	70	\$3,000	\$5,000	\$7,500 <sup>a</sup>	
Also, if yes, do you typically ask participants to pay an individual credit recording fee?	2000 <sup>b</sup>	9%	91%	34	\$20	\$20	31	23
	2002	45%	55%	47	\$15	\$20	\$25	

<sup>a</sup> See text for description of fees that vary by the program budget or number of participants.

<sup>b</sup> Questions asked about commercially funded self-study activities in 2000 and about all self-study activities in 2002.

About half of schools provide an annual transcript of CME credit to physicians external to the institution. About 40% of these schools charge a fee for the transcript, with a median fee of \$25. These results generally parallel those from 1996.

**Fees when working with communication companies.** The survey updated and expanded upon information asked two years ago about working with communication companies. The activities and results are presented in Table 28.

Now 59% of medical schools designate credit for “satellite symposia” produced by a communications company and held in conjunction with a major medical society meeting. This is a slight increase over 2000. About half of these schools charge a fixed fee to designate credit, with a median fee of \$5,000 (see Table 28). A few additional schools have fees that vary based on the budget or on the number of participants. Three institutions charge 10% to 20% of the budget. One charges \$5,000 plus 5% of the budget. Six

institutions charge a combination of a fixed fee plus an additional fee per participant, ranging from \$500 plus \$5 per participant to \$2,500 plus \$25 per participant.

Two-thirds of medical schools designate credit for an enduring material developed by a communications company, a slight increase over 2002. Schools that charge fixed fees charge amounts that are similar to those for satellite meetings (see Table 28). A few additional schools have variable fees, which parallel those for satellite meetings. For example, 10% to 20% of the budget, \$5,000 plus 5% of the budget, and from \$1,000 plus \$25 per credit request to \$3,000 plus \$20 per credit request.

Rather than building a fee for recording credit into the charge for designating credit, some schools ask individual participants to pay a recording fee. Of those schools that produce enduring materials with communication companies, 55% charge

TABLE 29. Distribution of Medical Schools on Location of Web Servers

On whose web-servers are your Internet CME self-study activities located? (check one)					
All on my own institution's servers	Majority are on my institution's servers	About half on my institution's servers and half elsewhere	Majority on other organization's servers	All on other organization's servers	N
37%	13%	13%	13%	24%	38

TABLE 30. Distribution of Medical Schools on CME Self-Study Over the Internet

	No	Some-times	Yes	N	If Fee, the Usual Fee			N
					25th %tile	50th %tile	75th %tile	
<u>For institutions offering Internet CME self-study</u>								
For Internet CME self-study Activities, do you charge a fee for participants to:								
a. access the activities	74%	17%	9%	35	\$15	\$50	\$395	3
b. record credit for the activities	34%	24%	42%	38	\$15	\$20	\$25	24
<u>For institutions NOT offering Internet CME self-study</u>								
Does your institution plan to offer CME self-study by Internet in the next year?								
	38%		62%	29				

participants a recording fee. This number is appreciably lower than two years ago. Presumably the recording fee is now more often bundled into the overall credit designation arrangement. When a fee is charged, the median is \$20 (see Table 28).

### CME Self-Study Over the Internet

Table 7 showed that approximately half of the respondents offer self-study CME over the Internet. Supplementary questions were asked to clarify some operational aspects.

One question concerned the location of the web-servers with the Internet CME activities. The results are presented in Table 29. The location arrangements vary appreciably, with roughly one-third of the institutions using their own servers, one-third using other organization's servers, and one-third using a combination of these locations.

Questions about fees for Internet self-study CME activities were also asked (see Table 30). The substantial majority (74%) do not charge a fee to access the activity. The few schools charging access fees have a wide range in the amount charged. Almost half of the schools charge a fee for recording credit, with a median charge of \$20.

Schools that do not currently offer CME on the Internet were asked if they planned to do so in the next year. Of those 29 schools, the majority (62%) responded that they plan to.

### Commercially Supported Social Events and Meals

One of the responsibilities of individuals in charge of CME activities is to be aware of the guidelines and requirements regarding the use of commercial funds. No restrictions are placed on how funds from participant's registration fees are spent. If registrants are willing to pay for it, you can arrange lavish entertainment and meals. However, restrictions are placed on the use of commercial funds because of the potential to provide personal benefits and inducements that might inappropriately influence judgements concerning the products of the commercial funder. Individuals in charge of CME are often expected to be the most knowledgeable individuals at their institutions about guidelines in using commercial support. This section of the survey included a test concerning knowledge and application of guidelines relevant to commercially funded social events and meals.

**Whose guidelines apply?** One pair of questions asked whether CME activities with AMA PRA category 1 credit had to be consistent with the ACCME Standards for Commercial Support and with the AMA Ethical Opinion on Gifts to Physicians from Industry. The questions and responses are presented in Table 31.

TABLE 31. Distribution of Medical Schools on CME Activities Meeting ACCME and AMA Requirements on Commercial Support

	False	Uncertain	True	N	Answer
CME activities with AMA PRA category 1 credit must be consistent with:					
a. ACCME Standards for Commercial Support	3%	0%	<b>97%</b>	68	True
b. AMA Ethical Opinion on Gifts to Physicians from Industry	5%	3%	<b>92%</b>	65	True

TABLE 32. Distribution of Medical Schools on ACCME and AMA Requirements Concerning Commercially Supported Social Events

	False	Uncertain	True	N	Answer
Regarding commercially supported social events during CME activities, the <u>ACCME Standards</u> :					
a. do not address commercially supported social events	<b>91%</b>	1%	8%	66	False
b. state that social events should be modest	59%	9%	<b>32%</b>	65	True
c. state that the event should facilitate discussion among attendees and/or with faculty	<b>75%</b>	10%	15%	67	False
d. state that social events should not compete with, or take precedence over the educational event	6%	0%	<b>94%</b>	68	True
e. state that the educational part should account for a substantial majority of the total time	<b>58%</b>	8%	34%	65	False
f. state that the social activity should be under \$100 in value	<b>91%</b>	6%	3%	65	False
Regarding commercially supported social events during conferences and meetings, the <u>AMA ethical opinion and addendum</u> :					
a. do not address commercially supported social events	<b>77%</b>	11%	12%	65	False
b. state that social events should be modest	18%	16%	<b>66%</b>	62	True
c. state that the event should facilitate discussion among attendees and/or with faculty	37%	19%	<b>44%</b>	62	True
d. state that social events should not compete with, or take precedence over the educational event	<b>25%</b>	9%	66%	64	False
e. state that the educational part should account for a substantial majority of the total time	31%	16%	<b>53%</b>	62	True
f. state that the social activity should be under \$100 in value	<b>68%</b>	14%	18%	62	False

CME activities have to follow both sets of guidelines. In order to be accredited as a CME provider, ACCME Essential Areas, Elements, and Policies must be followed (see page 1 of “ACCME’s Essential Areas and Their Elements,” [www.accme.org/incoming/17\\_system98\\_essential\\_areas.pdf](http://www.accme.org/incoming/17_system98_essential_areas.pdf)). ACCME Element 3.3 requires adherence to the Standards. In order to designate AMA PRA category 1 credit for an activity, the AMA Ethical Opinion must be followed (see page 5 of the AMA’s “Physician’s Recognition Award: Information Booklet for CME Providers,” [www.ama-assn.org/ama/upload/mm/44/sponsors.pdf](http://www.ama-assn.org/ama/upload/mm/44/sponsors.pdf); also see the AMA Ethical Opinion [www.ama-assn.org/ama/upload/mm/397/pocket.pdf](http://www.ama-assn.org/ama/upload/mm/397/pocket.pdf) and its Addendum [www.ama-assn.org/ama/upload/mm/369/gifts\\_clarification.pdf](http://www.ama-assn.org/ama/upload/mm/369/gifts_clarification.pdf)).

Table 31 shows that most – but not quite all – respondents are aware that these two sets of guidelines should be followed.

**Guidelines for commercially supported social events.** Respondents were asked whether each of a set of statements about commercially supported social events was in the ACCME Standards. The statements and responses are presented in the top half of Table 32.

The ACCME Standards make two statements regarding commercially supported social events:

6. Commercially Supported Social Events: Commercially supported social events at CME activities should not compete with, nor take precedence over the educational events.

8.a. Expenses of Non-Faculty Attendees: Subsidies for hospitality should not be provided outside of modest meals or social events that are held as part of the activity.

The top half of Table 32 shows that only 32% are aware of the part of Standard 8.a stating that social events should be modest. In contrast, 94% recognized Standard #6 regarding social events not taking precedence over educational events. Majorities thought that four other statements were not in the Standards, which is correct.

Respondents were asked whether each of a set of statements about commercially supported social events was in the AMA Opinion and its Addendum. The statements and responses are presented in the lower half of Table 32.

The AMA Ethical Opinion and its Addendum provide more detailed guidance concerning commercially supported social events. The general guideline is:

5. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting.

The Addendum further elaborates this statement in answering two questions.

(m) What kinds of social events during conferences and meetings may be subsidized by industry?

Social events should satisfy three criteria. First, the value of the event to the physician should be modest. Second, the event should facilitate discussion among attendees and/or discussion between attendees and faculty. Third, the educational part of the conference should account for a substantial majority of the total time accounted for by the educational activities and social events together. Events that would be viewed (as in the succeeding question) as lavish or expensive should be avoided. But modest social activities that are not elaborate or unusual are permissible, e.g., inexpensive boat rides, barbecues, entertainment that draws on the local performers. In general, any such events that are a part of the conference program should be open to all registrants.

(n) May a company rent an expensive entertainment complex for an evening during a medical conference and invite the physicians attending the conference?

No. The guidelines permit only modest hospitality.

The lower half of Table 32 shows that correct responses ranged from 25% to 77% across the items, a fairly wide distribution with a quarter or more of the respondents not correct on any one statement.

**Guidelines for commercially supported meals.** Respondents were asked to identify from a list of statements the one from the ACCME Standards concerning commercially supported

meals. The statements and responses are presented in the first section of Table 33.

One of the ACCME Standards addressing social events also addresses meals:

- 8.a. Expenses of Non-Faculty Attendees: Subsidies for hospitality should not be provided outside of modest meals or social events that are held as part of the activity.

The first section of Table 33 shows that half of the respondents identified the correct statement and half did not.

Respondents were asked to identify from a list of statements the one from the AMA Opinion and Addendum regarding commercially funded meals in conjunction with a speaker. The statements and responses are presented in the middle section of Table 33.

The AMA Opinion's general guidelines address meals at two points. In the general guidelines:

1. Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals and other gifts are appropriate if they serve a genuine educational function.
5. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting."

In 2000 the Addendum was updated to clarify what is meant by "modest meals." Clarification of "modest meals" was made in responding to a question about the use of the term in Guideline 1, but applies generally to the use of the term "modest meals," including Guideline 5.

(d) When companies invite physicians to a dinner with a speaker, what are the relevant guidelines?

First, the dinner must be a modest meal . . . the meal should be a modest one similar to what a physician routinely might have when dining at his or her own expense. In an office or hospital encounter with a company representative, it is permissible to accept a meal of nominal value, such as a sandwich or snack."

The middle section of Table 33 shows that only 25% are aware of the definition of a modest meal. Half think the meaning is not clarified.

Respondents were asked to identify from a list of statements the one from the AMA Opinion and Addendum regarding meals provided by a commercial company representative in conjunction with an office or hospital encounter. The responses are presented in the last section of Table 33. Again, only 22% are aware of the definition of a modest meal in this circumstance and half think the meaning was not clarified.

TABLE 33. Distribution of Medical Schools on ACCME and AMA Requirements Concerning Commercially Supported Social Meals

	True	N	Answer
Regarding meals funded by commercial sources in conjunction with CME activities, <u>the ACCME Standards</u> : (check one)		70	
a. do not address the value of meals	39%		False
b. state that meals should be modest, but do not clarify the meaning of "modest"	<b>50%</b>		True
c. state that meals should be of nominal value, such as a sandwich or snack	0%		False
d. state that meals should be modest, similar to what a physician routinely might have when dining at his or her own expense.	9%		False
e. state that a meal should be under \$100 in value	2%		False
Regarding meals funded by commercial sources in conjunction with a speaker, <u>the AMA ethical opinion and addendum</u> : (check one)		67	
a. do not address the value of meals	9%		False
b. state that meals should be modest, but do not clarify the meaning of "modest"	55%		False
c. state that meals should be of nominal value, such as a sandwich or snack	0%		False
d. state that meals should be modest, similar to what a physician routinely might have when dining at his or her own expense.	<b>25%</b>		True
e. state that a meal should be under \$100 in value	10%		False
Regarding meals provided by a commercial company representative in conjunction with an office or hospital encounter, <u>the AMA ethical opinion and addendum</u> : (check one)		64	
a. do not address the value of meals	15%		False
b. state that meals should be modest, but do not clarify the meaning of "modest"	50%		False
c. state that meals should be of nominal value, such as a sandwich or snack	<b>22%</b>		True
d. state that meals should be modest, similar to what a physician routinely might have when dining at his or her own expense.	8%		False
e. state that a meal should be under \$100 in value	5%		False

**Applying the guidelines.** The remaining set of questions on this topic asked respondents to apply the guidelines that they were aware of to a list of social events and meals. Respondents were to assume the event was commercially supported and held in conjunction with a two day CME activity. The list of activities and responses are presented in Table 34.

Summarizing the ACCME and AMA guidelines, social events should:

- Be of only modest value to physicians
- Take a substantial minority of the total time and not compete with the educational activity
- Facilitate discussion

Similarly, meals should:

- Be modest – similar to what physicians routinely might have
- Take a minority of the total time and not compete with the educational activity

In this example criterion “b” above (minority of time and not competing with the educational activity) is not a concern because each event would take only a few hours of a two-day

educational activity. The remaining concerns are whether the events are (a) modest and (c) whether the social activities facilitate discussion.

- Broadway play. (a) The likely value is appreciable. (c) The event does not facilitate discussion.
- Concert by sponsoring school’s Glee Club. (a) The likely value is modest – the AMA Addendum specifies “entertainment that draws on the local performers.” (c) A reception or time that facilitates discussion should be included.
- Professional basketball game. (a) The likely value is appreciable. (c) The event does not facilitate discussion.
- Gourmet food “tasting” and meal. (a) The likely value is appreciable. The meal is not “a modest one similar to what a physician routinely might have when dining at his or her own expense.”
- Barbecue dinner and western dance. (a) The likely value should be modest: meal similar to what a physician might routinely have and local dance band. (c) The event facilitates discussion.

TABLE 34. Distribution of Medical Schools on Views Concerning Appropriate Commercially Supported Social Events and Meals

	Inappro- -prie	Un- certain	Appro- -prie	N	Answer *
According to the national guidelines that you believe apply, how appropriate do you think each of the following social events would be if the event were commercially supported and held in conjunction with a two day CME activity?					
a. Broadway play	<b>69%</b>	14%	17%	72	Inappropriate
b. Concert by sponsoring school's Glee Club	14%	11%	<b>75%</b>	71	Appropriate
c. Professional basketball game	<b>72%</b>	11%	16%	72	Inappropriate
d. Gourmet food "tasting" and meal	<b>22%</b>	33%	45%	72	Inappropriate
e. Barbecue dinner and western dance	18%	18%	<b>64%</b>	72	Appropriate
f. Special show by national entertainer (e.g., Jay Leno)	<b>70%</b>	17%	11%	72	Inappropriate
g. Evening boat excursion	27%	<b>15%</b>	58%	72	Uncertain

\* See text for assumptions in determining answers.

TABLE 35. Distribution of Medical Schools on CME Accreditation Requirements for Medical Schools

Medical schools differ from other types of CME providers in some ways, e.g., having to provide CME to academic faculty who teach medical students and residents. Are there special circumstances for medical schools that should result in ACCME having for them:	No	Yes	N
a. different essential elements and standards for accreditation?	82%	18%	67
b. different requirements for compliance and documentation?	72%	28%	67
c. different requirements for reporting annually to ACCME?	86%	14%	66
d. other different requirements?	85%	15%	60

- Special show by national entertainer. (a) The likely value is appreciable. (c) The event does not facilitate discussion.
- Evening boat excursion. (a) In this statement the likely value is not clear. The AMA Addendum specifies "inexpensive boat rides." The cost of the excursion should be clearer in order to determine whether it is inexpensive or not. (c) A group excursion is likely to facilitate discussion.

- AMA Council on Ethical and Judicial Affairs 312-464-4823

[Editorial comment: When violations of these guidelines occur, the violations are often prominent in course advertisements. Commercial funds are sometimes inappropriately used to provide personal inducements in order to increase attendance at an educational activity. An obvious "red flag" is a brochure that features expensive entertainment or meals at the most expensive local restaurant.]

### CME Accreditation for Medical Schools

Medical schools differ from other types of CME providers in some ways, e.g., having to provide CME to academic faculty who teach medical students and residents. Four questions were asked about having different accreditation requirements for medical schools than for other CME providers. The questions and responses are presented in Table 35.

The substantial majority (72% to 86%) of respondents believe that medical schools should have the same essentials and standards for accreditation, the same requirements for compliance and documentation, and the same reporting

The pattern of results in Table 34 shows that no overwhelming majority was correct for any one situation. A substantial majority were correct on five items and only a minority were correct on two items.

Across Tables 31-34, the results suggest that most respondents recognize they must apply ACCME and AMA guidelines. Although the majority of respondents are familiar with many of the specific guidelines and their application, the majority are not familiar with some of the guidelines and their application.

Questions about the guidelines and their application can be directed to:

- ACCME 312-464-2500 (ask for Kathy Johnson)

TABLE 36. Suggestions for Changes to CME Accreditation Requirements for Medical Schools  
(From those responding “Yes” in Table 35)

a. Different essential elements and standards for accreditation?

Rounds, conferences, etc.  
Grand rounds activities for internal audience – different  
Grand rounds  
Mission relates to students/residents  
Require research  
Less needs assessment  
Medical school CME departments are included in the LCME accreditation process. We feel that this is the proper mechanism for approving medical CME departments and granting them the authority to designate category 1 credit

b. Different requirements for compliance and documentation?

Grand rounds  
Grand rounds  
Rounds, conferences, etc.  
Grand rounds  
Grand rounds  
In-house conferences  
Reduce documentation  
Exclude in-hospital conferences from usual documentation.  
Whereas school sponsored rounds (not pharmaceutically supported) are based on leading edge research and innovation, disclosures and off-label announcements are distracting. Most of what is discussed is off-label. FDA approval and labeling was designed to regulate pharmaceutical advertising, not academic medical discourse.

b. Different requirements for compliance and documentation?  
(continued)

Rounds that are planned by academic teaching faculty should be exempt from the standards and essentials. Typically they are designed by medical education experts and address leading issues and discoveries. Unless the rounds are pharmaceutically supported, CME credit should be granted without CME staff involvement in needs assessment, planning, and educational design.  
Less stringent because of decentralization of medical schools  
Part of LCME accreditation  
Credit for teaching medical students

c. Different requirements for reporting annually to ACCME?

Exclude in-hospital conferences from usual documentation  
In-house conferences  
Must earn specified number of credits

d. Other different requirements?

Should be part of LCME review  
Part of LCME accreditation  
Longer accreditation periods (like LCME)  
Ability to record (with CME credit) learning that accompanies teaching medical students and residents  
Should be educated about teaching/mentoring

requirements. Some of the minority wanting different requirements described the areas of change. Those suggestions are listed in Table 36. The major theme is to have different requirements for grand rounds. This includes requirements regarding application of essential elements, documentation, and reporting.

The previous three surveys asked whether medical schools should have the same requirements for CME accreditation as other CME providers. In 1996, 60% agreed with the same requirements (6% neutral). In 1998, 44% agreed (21% neutral). In 2000 the wording was change to “A new approach should be developed for the accreditation of medical school’s CME programs.” – 32% supported the current approach (10% neutral). The trend was for a decreasing number to support the same/current requirements for medical schools: 60%, 44%, 32%. The findings this year run counter to that trend with support for current requirements at 72% to 86%. Part of the variation across years may be due to the different wording of questions. However, it appears that current views are closer to those of six years ago than more recent years.

## AMA Category 2 Designation Change

In 2001 the AMA eliminated the ability of accredited CME providers to designate category 2 credit for the institution’s CME activities that did not meet all of the requirements for category 1 credit. One question asked whether this change caused a problem or was helpful. The responses are presented in Table 37. The change made no difference at the substantial majority of medical schools (84%) and only small difference to most of the remaining schools.

## Summary

CME units and personnel share an overall mission to ensure that high quality CME programs are developed and produced at medical schools. The results of the biennial surveys continue to demonstrate diversity across medical schools in the types and amounts of programming and in organizational and operational arrangements for CME units and CME personnel. The intent of the survey is not to produce an overall integrated view of CME units and their activities, but to highlight areas

TABLE 37. Distribution of Medical Schools on Effect of Eliminating Institutional Designation of AMA Category 2

Last year the AMA eliminated the ability of accredited CME providers to designate category 2 credit for the institution's CME activities that did not meet all of the requirements for category 1 credit. For your institution this change:					
Caused a large problem	Caused a small problem	Made no Difference	Was a small help	Was a large help	N
0%	9%	84%	6%	1%	69

and issues of particular interest. Summarized below are some of the major findings regarding topics in this year's survey.

**Current trends.** The largest increase is in the reported quality of courses. Modest decreases are occurring in attendance at pleasure courses, financial support from commercial companies, financial support from the university, and time between registering and the course date. For the other items, the overall trend is close to no change, with some individual institutions experiencing changes in both decreasing and increasing directions.

When looking at trends across years, the biggest change is the shift from previously increasing commercial support now to decreasing commercial support. The number of courses for external physicians and faculty interest in participating in the school's CME are both now stable, a change from past patterns of slight to moderate increases. Attendance at pleasure courses decreased, a change from the stability of recent years and more than decreases in the early 1990's. The trends across time on the other measures have been generally similar for several years. Sustained trends are for increases in the quality of courses and decreases in financial support from the university and in time between registering and the course date. Generally stable across years are the number of external physicians per course and faculty interest in participating in other sponsors' CME activities.

**Programs and attendees.** Regarding live, in person courses for external physician attendees, in 2000–01 the typical (median) medical school produced 70 courses with 786 hours of credit and had an annual attendance of 3,536 physicians and 2,039 other participants. Each of these numbers is slight increase over two years ago.

Other forms of live CME for external audiences vary in their prevalence across medical schools. Half (46%) of medical schools arrange presentations at county medical societies and local hospitals. A minority medical schools broadcast live conferences by television (24%), telephone (20%), or Internet (7%). One-third of medical schools offer individual tutorials or traineeships, with a trend across years for fewer schools to offer them.

Regarding self-study CME activities, 80% of medical schools offer self-study activities: 62% in written form, 53% Internet, 41% video, 37% computer disks, and 28% audio. Schools typically produce fewer than ten self-study activities per year.

The number of schools producing self-study activities did not change appreciably from two years ago.

Virtually all schools designate credit for some ongoing multiple session internal activities such as grand rounds – the median is 38 activities with schools varying widely on the number. The majority of schools designate credit for a few single occasion internal activities. Regarding activities for which credit was not designated, but probably could be if “paper work” requirements were performed, the majority of schools have a few additional internal activities that could be converted from not-for-credit to for-credit. These numbers are fairly stable across years.

**Course fees.** The usual fee per credit hour ranges widely across medical schools. Fees for courses at the institution's primary location (median of \$18/credit hour) have increased slightly. Fees for courses at “pleasure” locations (median of \$25/credit hour) have not changed appreciably.

**Faculty honoraria.** For local faculty at “home” courses, 63% of the schools pay no honorarium. Honoraria are sometimes paid at 25% of the medical schools – a median payment of \$500 when sufficient course income is available. Honoraria are usually paid at 12% of the schools, with a median payment of \$250. For local faculty at courses in “pleasure locations,” 55% of medical schools do not pay honoraria, 7% pay sometimes (median \$500), and 33% pay usually (median \$850). The percent of schools under the three payment arrangements has not changed appreciably. When honoraria are paid, some of the amounts have increased.

For guest faculty the median honorarium payment is \$1,000, with 80% of schools having typical payments that range from \$500 to \$1,500. The results were generally similar for courses at the institution's primary location and at resort locations. These amounts are \$250 higher than the amounts reported four years ago.

**Characteristics and salaries of “Directors of CME.”** The role of the “director” was defined as the person with immediate responsibility for the overall CME program. For the individual with this role, information about several characteristics was obtained. On education level, 7% are high school graduates, 3% have bachelor's degrees, 46% have master's degrees, 27% have doctoral degrees, and 17% have medical degrees. On gender, 66% are women. The mean years of work experience is 25 years, with a mean of 13 years

of CME experience. For actual title of person, individuals who

are high school graduates or have bachelors degrees are Coordinators or Directors, individuals with masters degrees are usually Directors, individuals with doctoral degrees are Directors or Assistant/Associate Deans, and physicians are usually Assistant/Associate Deans. For 85% the primary work responsibility is being "Director of CME." While this is the primary job responsibility for most non-physicians, the majority of physicians do not have "Director of CME" as their primary job responsibility. The number of staff supervised in the CME unit varies widely with a mean of 8.0.

Comparing 1990 to 2002, the largest shift is the reduction in the number of physicians from 41% to 17% and the increase in the number with master's degrees from 23% to 46%, probably reflecting the increase in day-to-day administrative responsibilities. The percentage of women has increased from 41% to 66%, particularly at the master's degree level and some what at higher education levels. "Directors" are more likely to have being "Director of CME" as their primary work responsibility (from 63% to now 85%), to spend a higher proportion of work time being the "Director" (from 67% of time to now 82% of time), and likely to have a somewhat larger staff (from 5.0 FTE to now 8.0 FTE).

Salaries of "Directors" were primarily associated with their professional training. The median salary levels were: high school or bachelor's degree, \$52,000; master's degree, \$65,000; doctoral degree, \$100,000, and physician, \$175,000. The small sample size within each level of training limits the interpretation of these values to general indications concerning salary levels.

**CME reporting structure.** The substantial majority (86%) of CME units have upward reporting structures through the Dean of the medical school. Others generally report through hospitals or an academic health center that encompasses schools for several health professions. For schools that report through the Dean, the number of reporting levels to the Dean is related to the job title: Associate Deans generally report directly to the Dean, Assistant Deans and Directors tend to report to an intermediary, and Coordinators tend to have one or two intermediary levels.

**CME unit financing.** Medical school CME units vary greatly in their financing arrangements for CME due to differences across a number of local factors. While the ranges are wide, the median CME unit revenue is \$1.5 million with a net surplus of \$30,000. Commercial funds are now the largest source of CME revenue, followed by registration fees. Only 60% of CME units receive direct funding from the medical school and the funding amount has not changed appreciably over eight years. The majority of medical schools provide office space, central business services (e.g., payroll), and course meeting space at no charge to the CME unit. These additional costs are typically not included in unit expenses.

While individual courses may have a variety of financial arrangements, at 68% of schools a production fee is paid to the CME unit and the course deficits and surpluses go to the

cosponsoring department. The production fees vary widely due to the different cost structures across CME units. The median fees are \$1,500 for a half day course, \$3,000 for a one day course, \$4,000 for a two day course, and \$5,500 for a three day course. For the 16% of institutions that share course deficits and surpluses with the cosponsoring department, the typical arrangement is a 50%/50% split for both deficits and surpluses. Compared to 1994, more CME units now have fixed fees guaranteed by the cosponsoring department and fewer CME units share in course deficits and surpluses.

Only 18% of CME units have to share a percentage of gross revenue with a higher level institutional unit. Half of these CME units give a percentage of gross revenue to the medical school (median 10%) and half give a percentage to the university (median 7.5%).

If CME units have a net deficit for the fiscal year, about half carry forward the deficit to pay off in the next year and about half transfer the deficit to the institution and start the new year with a zero balance. If CME units have a net surplus for the fiscal year, a somewhat larger number (63%) would carry forward the surplus than would transfer it to the institution.

**Some fees charged by the CME unit.** Regarding internal CME activities, virtually all schools designate credit for internal activities such as grand rounds, with 42% of schools charging a fee (median \$300) for this service. The majority (72%) of schools provide an annual transcript of internal CME credit to physicians internal to the institution, with 16% of these schools charging a fee (median \$25) for the transcript. About half of schools provide an annual CME transcript to external physicians, with about 40% of these schools charging a fee (median \$25).

Regarding fees when working with communication companies, 59% of schools designate credit for a "satellite symposium" held with a major society meeting. About half of these schools have a fixed fee (median \$5,000) and the other half have schedules that vary based on the budget or the number of participants. Two-thirds of schools designate credit for enduring materials produced with communication companies, with fees similar to those for satellite meetings. Of these schools, about half also typically ask participants to pay an individual credit recording fee (median \$20).

**CME self-study over the Internet.** About half of medical schools offer CME self-study over the Internet. When asked about the location of the web-servers, roughly one-third use their own servers, one-third use other organization's servers, and one-third use servers at a combination of locations. Only 9% regularly charge a fee to access the self-study activities, but almost half (42%) do charge a fee (median \$20) to record participation for credit. Of 29 institutions not offering self-study over the Internet, half anticipate offering it in the next year.

**Commercially supported social events and meals.** The survey included a test concerning knowledge and application of ACCME and AMA guidelines relevant to commercially funded social events and meals. Almost all respondents are aware that both the ACCME and AMA guidelines must be followed. In answering questions about the ACCME and AMA guidelines concerning social events and meals, the majority of respondents are familiar with many of the specific guidelines and their application, but the majority are not familiar with some of the guidelines and their application. Respondents were least familiar with guideline concerning meals, including the AMA's guidelines that commercially funded meals should be "modest," i.e. "similar to what a physician routinely might have when dining at his or her own expense."

**CME accreditation of medical schools.** The survey asked if medical schools should differ from other CME providers in requirements for CME accreditation. The substantial majority (72% to 86%) believe that medical schools should have the same essential elements and standards, the same requirements for compliance and documentation, and the same reporting requirements. For those with different views, the major theme was that grand rounds at medical schools should have different requirements.

**AMA category 2 designation change.** In 2001 the AMA eliminated the ability of accredited CME providers to designate category 2 credit for the institution's CME activities that did not meet all of the requirements for category 1 credit. This change made no difference at 84% of medical schools and only a small difference to most other schools.

## Suggestions for the Next Survey

The Survey Subcommittee extends our appreciation to the CME directors and personnel who completed and returned this year's survey. Their willingness to provide information makes this report possible.

We invite members to submit suggestions to be included in the next survey. The work that goes into developing the survey, responding to it, and assembling the results is worthwhile only if the information is useful to the membership. We welcome your suggestions.

## APPENDIX

### Definitions Used for Audiences, Programs, and Locations

**Program information.** This section requests an annual summary of the programs you have offered for the past year. The terminology is explained below to clarify the question (and your responses). (A page of definitions may appear to be overkill. However, with the diversity among CME units the possibilities for confusion are enormous - - a lot more than you are thinking right now. You have to be on the receiving

end of the completed surveys to begin to appreciate the variety -- and creativity -- our unguided energies can produce.)

**Target audience.** Physician oriented programs -- programs planned with physicians as an important portion of the audience, i.e., at least 25% of the expected audience and typically the majority of the audience.

External participants -- individuals attending your CME programs who are not closely associated with your institution; they typically do not have an appointment with the medical college/school, usually do not attend "internal" meetings such as department meetings, and usually are expected to pay registration fees for your CME programs. (A few schools have decided for local reasons to extend "courtesy" appointments to a large number of "community" physicians and even offer them CME at no charge. However, if they are not functionally part of the medical school/college, they should be classified as "external.")

Internal participants -- individuals attending your CME programs who are employed by your institution; they typically have an appointment with the medical college/school, they are invited to and usually attend "internal" meetings such as department meetings, and usually do not pay registration fees for your CME programs. (A few schools charge everyone a registration fee. If individuals are functionally part of the medical college/school, they should be classified as "internal.")

**Types of educational programs.** Live, in-person courses, conferences, and seminars -- the usual multiple hour and often multiple day programming for CME. Individual promotional efforts are usually associated with each of these meetings.

Presentations at county medical societies and local hospitals -- usually of limited length, routinely scheduled, and involving little if any promotional activity and a limited and defined set of individuals that are invited to attend.

Telephone and television conferences -- media transmission of events occurring elsewhere or previously.

Individual tutorials and traineeships -- participant usually comes to the designated training location.

Self-study courses, either written, audio, video or computer based (from disk or via Internet) -- participant does independently, usually at home.

Internal meetings -- grand rounds, medical conferences, and other meetings primarily for members of the faculty and staff of the medical college/school.

**Locations.** Primary site -- the usual location for your programs. For most medical colleges/schools, this location is at or near the medical college/school.

Pleasure locations -- resorts and cities that are often visited by tourists and vacationers.

**THANK YOU!**

The following medical schools completed and returned the 2002 SACME questionnaire. The medical schools followed by an asterisk ( \*) returned it by February 28, 2002, a noteworthy accomplishment. The Survey Subcommittee extends a special thanks to the institutions below on behalf of the membership.

**ALABAMA**

University of South Alabama\*

**ARIZONA**

University of Arizona Health Sciences Center

**ARKANSAS**

University of Arkansas for Medical Sciences\*

**CALIFORNIA**

Stanford University School of Medicine  
University of California – Los Angeles  
University of California- San Francisco\*  
University of California –San Diego\*

**COLORADO**

University of Colorado School of Medicine\*

**FLORIDA**

University of Miami School of Medicine\*  
University of South Florida College of Medicine\*

**GEORGIA**

Emory University School of Medicine\*  
Mercer University School of Medicine\*

**ILLINOIS**

Loyola University Stritch School of Medicine\*  
Rush Medical College\*  
Southern Illinois University School of Medicine\*  
University of Chicago Pritzker School of Medicine\*  
University of Illinois at Chicago\*

**INDIANA**

Indiana University School of Medicine

**IOWA**

University of Iowa College of Medicine\*

**KENTUCKY**

University of Kentucky\*  
University of Louisville\*

**LOUISIANA**

Tulane University Health Sciences Center\*

**MARYLAND**

Johns Hopkins University  
Uniformed Services University of the Health Sciences\*

**MASSACHUSETTS**

Boston University School of Medicine\*  
Harvard Medical School\*  
Tufts University School of Medicine\*  
University of Massachusetts Medical School\*

**MICHIGAN**

University of Michigan Medical School\*  
Wayne State University School of Medicine

**MINNESOTA**

Mayo School of Continuing Medical Education  
University of Minnesota

**MISSOURI**

University of Missouri – Kansas City\*  
Washington University School of Medicine

**NEBRASKA**

Creighton University\*  
University of Nebraska Medical Center\*

**NEW HAMPSHIRE**

Dartmouth Medical School

**NEW JERSEY**

University of Medicine & Dentistry of New Jersey\*

**NEW MEXICO**

University of New Mexico School of Medicine

**NEW YORK**

Albany Medical College\*  
SUNY at Stony Brook  
SUNY Upstate Medical University  
University of Buffalo\*  
University of Rochester\*  
Weill Medical College of Cornell University

**NORTH CAROLINA**

Brody School of Medicine, E Carolina University\*  
Duke University Medical Center

**OHIO**

Northeastern Ohio University College of Medicine\*  
University of Cincinnati\*

**OKLAHOMA**

University of Oklahoma College of Medicine\*

**OREGON**

Oregon Health & Science University

**PENNSYLVANIA**

MCP Hahnemann University School of Medicine  
Penn State College of Medicine\*  
Temple University School of Medicine\*  
University of Pittsburgh\*

**RHODE ISLAND**

Brown Medical School\*

**SOUTH CAROLINA**

Medical University of South Carolina\*  
University of South Carolina\*

**SOUTH DAKOTA**

University of South Dakota School of Medicine

**TENNESSEE**

Vanderbilt University School of Medicine

**TEXAS**

Texas A & M College of Medicine\*  
Texas Tech University Health Sciences Center\*  
University of Texas Health Science Center at San Antonio\*  
University of Texas Medical School at Houston  
University of Texas Southwestern Medical Center at Dallas

**VERMONT**

University of Vermont College of Medicine

**VIRGINIA**

Eastern Virginia Medical School\*  
University of Virginia School of Medicine

**WEST VIRGINIA**

Marshall University School of Medicine\*

**WISCONSIN**

University of Wisconsin Medical School

**CANADA**

Dalhousie University Faculty of Medicine\*  
University of Calgary\*  
University of Ottawa  
University of Toronto Faculty of Medicine\*