

## SACME SPRING MEETING 2002 A RESOUNDING SUCCESS

The SACME Spring meeting, held April 11-14, 2002 in Charleston, South Carolina, was one of the most successful in recent years. Hosted by the Medical University of South Carolina, it was attended by 120 registrants, guests, and vendors, a record number of people. Of the 102 registrants, 29 were non-members.

Many new and exciting changes were incorporated. The theme, "Knowledge Management," provided opportunity to showcase cutting-edge initiatives as well as take-home applications. Plenary sessions by Nancy Lorenzi, Ph.D. and David Slawson, M.D. were thought-provoking. New formats and sessions were offered including an optional Internet workshop, *Navigating Seas of Information* given by Anne Taylor-Vaisey, M.L.S., and a focused session on *Integrating the Core Competencies*

with *CME: Implementation Strategies and Best Practices*, moderated by Melinda Steele, M. Ed. Debate was lively in the Hot Topics session that included R. Van Harrison's summary of the Biennial Survey and latest trends in commercial support.

Exhibitors were invited for the first time this year. Prestige Resorts and Destinations, MMS, Inc., and Helium Networks, Inc. exhibited at the meeting and were extremely enthusiastic to be included. A tour and cookout at Boone Hall Plantation, whose Avenue of Oaks was used in creating the scenery for "Gone with the Wind," provided an opportunity for networking and social interaction.



Presentations and handouts from the meeting, as well as photographs, are on the SACME web site at [http://www.sacme.org/SACME\\_Meetings/Spring\\_2002/highlights.htm](http://www.sacme.org/SACME_Meetings/Spring_2002/highlights.htm).

Jack Kues, Ph.D., SACME's president, noted, "The planning and administration of this year's meeting were superb." The Program Committee was chaired by Melinda Steele, M.Ed., and included Joan Sargeant, M.Ed. (Vice Chair), Jan Temple, Ph.D., Nancy Davis, Ph.D., Jack Kues, Ph.D., Michael Allen, M.D., Lee Manchul, M.D., Jim Ranieri, Ellen Cosgrove, M.D., and John Boothby, M.S.W.



*Left: Robert Fox, Ed.D. presented a plaque to Jacqueline Wakefield, M.D., winner of the second annual Robert Fox Award for best abstract. Right: A most successful meeting planning team, from left to right, are Melinda Steele, M.Ed., Barbara Barnes, M.D., and Jan Temple, Ph.D.*

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# FROM THE PRESIDENT

By Jack Kues, Ph.D.

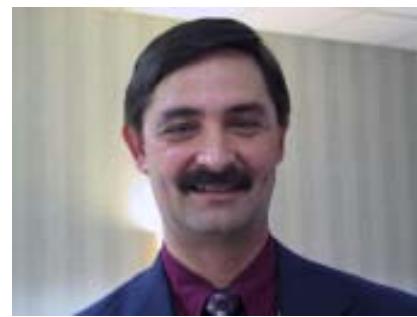
During the time I have been a member of SACME I have seen an explosion of action and productivity. It was not that many years ago that the vast majority of Society work took place in four or five days, twice a year, at our Spring and Fall meetings. In the interim, small groups phoned, wrote, and e-mailed each other to address critical issues and to prepare for our semi-annual gatherings. In the past several years, not a day has gone by without postings to the listserv. And in the past 18 months we have had at least weekly updates to our web page by Anne Taylor-Vaisey or Jim Ranieri. Almost every committee meets by conference call on a regular basis and the number of listservs for committees and other special interest groups in the Society has grown rapidly in the last year.

The business of the Society goes on 24/7 365 days a year. If we were a university or a business it would not be surprising to see this level of activity. However, we are a small volunteer organization and most of our members have demanding full-time jobs. The time and effort devoted to Society business is over and above hectic schedules and tight deadlines.

We have, above all else, learned to be efficient in our use of time and technology. We have identified important issues, examined the relevant literature, held lively discussions, developed action plans and posted everything on our web site in the period of a week. We have conducted needs assessments and other surveys on our web site and we have used the data to shape face-to-face discussions at our meetings. Most recently, Anne Taylor-Vaisey, motivated by a very successful workshop in Charleston, has been using the listserv to improve our information- seeking skills on the Internet.

The energy at our Spring and Fall meetings is palpable and contagious. We had a record number of non-members and new members in Charleston.

VISIT THE SACME WEB SITE AT  
[WWW.SACME.ORG](http://WWW.SACME.ORG)



It is very exciting for me to be working among so many talented and enthusiastic individuals. The diversity of perspectives and opinions on the issues before us will, no doubt, be met with open and honest discussions. Not too many years ago, we were trying to identify what unique role SACME, and its member institutions, could play within CME. We don't seem to have time for that debate these days. We are all too busy participating in the role we found so difficult to define just a short time ago.

## SACME MEMBER HONORED BY TEMPLE UNIVERSITY

Dr. Albert J. Finestone will be honored by the Temple University School of Medicine for his leadership and outstanding legacy as physician, teacher, researcher, administrator, and benefactor when the school's Office of Continuing Medical Education (CME) is renamed "The Albert J. Finestone, M.D. '45 Office of Continuing Medical Education at Temple University." The CME office was founded by Dr. Finestone in 1972, and he served as its associate dean for 20 years.

### INTERCOM

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# HIGHLIGHTS OF THE SACME 2002

## SURVEY REPORT

By R. Van Harrison, Ph.D.

Chair, Survey Subcommittee of the SACME Research Committee

Every two years the Society conducts a survey to collect and disseminate information about policies and practices at CME units in colleges and schools of medicine in the United States and Canada. This year's questionnaire was sent in late January to the 94 schools with which members of the Society are affiliated. Responses were received from 74 (79%) of the schools. A draft of the report was distributed to members attending the Spring meeting of the Society. The final report incorporates a few minor changes. The report is being distributed to members and is available for download as a *pdf* file on the Society's web site.

The purpose of the "Report on Descriptive Results" is to present the data with some limited discussion. Results on specific items may be used to address issues within medical schools, within the Society, and regarding the overall CME enterprise within North America. The report is primarily a reference document that members can use in addressing issues at any of these levels informally or in articles written for publication.

The report covers a variety of topics. Three broad topics are routinely included in SACME surveys: current trends, programs and attendees, and course fees. Four additional topic areas have been included periodically in surveys: faculty honoraria, CME director characteristics and salary, financial arrangements for CME units, and some fees charged by the CME unit. Five additional topic areas are unique to this survey: CME reporting structure, CME self-study over the Internet, knowledge of commercially supported social events and meals, CME accreditation of medical schools, and change in AMA category 2 credit designation.

Two interrelated major trends likely to be of general interest are (1) the increased dependence of CME on commercial support and (2) the decreasing financial support from medical schools for their CME units. Some of the findings regarding these and other topics are highlighted below.

### **Increased Commercial Support**

Several trends within medical school CME units are related



to increases in the availability of commercial support over the past eight years.

- Commercial support increased five-fold and is typically more than a half million dollars per year.
- Commercial support is now the largest revenue source for CME units, more than registration fees.
- The number of live CME activities has increased by more than 30%.
- The number of self-study CME activities has increased.
- The honorarium typically paid to guest faculty has doubled.
- Registration fees paid by participants have only increased slightly.
- The number of staff in the CME unit has increased by 50% (typically from 5 to 8).
- The most frequent training background of individuals in charge of CME units has shifted from being physicians to being individuals with master's degrees, reflecting the increased administrative responsibilities.

Some additional trends and their implications are relevant to the present and near future.

- After appreciable increases over several years, the amount of commercial support has stabilized and perhaps slightly decreased during the past year.
- The number of CME activities has also stabilized in the past year.
- Funding for traditional CME will be greatly affected by national factors that change expenditures for pharmaceutical advertising.
- The magnitude of commercial funding is likely to focus increasing attention on inducements and conflicts of interest that affect organizations developing and delivering CME.

## Medical School Funding for CME Units

The eight-year trends for medical school funding of CME are sobering.

- 40% of medical schools provide no direct central funding to the CME unit, up from 25%.
- Those CME units receiving funds are typically not receiving funding increases, resulting in a net effective decrease in funds each year due to annual cost-of-living increases.
- The majority of CME units now require guaranteed payment for production services, with content departments fiscally responsible for deficits and surpluses.
- The production fees charged by CME units to recover costs have doubled.
- CME units working with communication companies often charge an appreciable fee (e.g., \$5,000) as a revenue source for uncovered expenses.
- Medical school CME units continue to operate on a 2% margin of surplus revenue within the unit.

Looking to the near future:

- CME units are increasingly dependent on external sources of revenue.
- The trend for decreasing internal funding will result in CME units being even more greatly affected by national factors altering expenditures for pharmaceutical advertising.

## Some Other Trends

Several other noteworthy trends were evident in the results.

- Individuals in charge of CME units understand many, but not all of the details concerning appropriate and inappropriate use of commercial funds for social events and meals.
- Attendance at “pleasure” locations has recently decreased a little, presumably due to concerns about travel and terrorism.
- Live CME courses continue to increase in number, self-study is increasing somewhat, and distance CME is not changing.
- The majority feel that the ACCME accreditation requirements are appropriate for medical schools, but many would like the application of detailed requirements to grand rounds to be simplified.

Details concerning these trends and lots of other information are available in the report.



*Among the 2002-2003 Board Members are, from left, Craig Campbell, M.D., Vice President, Barbara Barnes, M.D., Past President, Nancy Davis, Ph.D., President-Elect, and Jack Kues, Ph.D., President.*

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# **JOURNAL OF CONTINUING EDUCATION IN THE HEALTH PROFESSIONS**

## **PROVIDES VEHICLE FOR DEVELOPING CME PROFESSION**

By Jocelyn Lockyer, M.H.A.

Director, Continuing Medical Education and Professional Development, University of Calgary

One of the most significant benefits received by Society for Academic Continuing Medical Education members is a subscription to the *Journal of Continuing Education in the Health Professions*.

You may feel that is a biased opinion from someone who has benefited from the journal as a reader, learner, writer, and now as chair of the Administrative Board—and you may be right. I see the journal as a vehicle for developing the profession of continuing medical education. It offers opportunities to learn about and present the theoretical foundations of our field, improve our original research, share innovative programs, and flag books that might be important to read. The journal is designed to be practical for use by those who plan, implement, or evaluate continuing education. Its scope is broad, including topics on cognition, motivation and behavior, health policy and professional performance, life-long learning skills development, and the measurement of educational and patient outcomes.

The *Journal of Continuing Education in the Health Professions* is the only “medical education” journal that is focused on the health professional after undergraduate, graduate, and residency training. It has shown up regularly in the mail for 22 years; and since 2000, it has been listed and indexed in Index Medicus as *J Contin Educ Health Prof*, making its content more widely available. Beginning in the summer of 2002, *J Contin Educ Health Prof* will be available on-line with full searching and archiving capability. With these innovations, our literature will be readily accessible throughout the world to students, academics, and professionals who might otherwise not be aware of our discipline and our scholarly activity.

Submissions as well as questions about possible journal articles are always welcome. Paul Mazmanian serves as Editor. Evelyn Hebbard serves as Editorial Assistant. Both are located at the Virginia Commonwealth University in Richmond, Virginia. Paul is responsible for editorial policy and process involving the receipt of manuscripts, peer review, communication with authors, and production. He works closely with an Editorial Group that includes Nancy Bennett, David Davis and me.

The *Journal of Continuing Education in the Health Professions* is owned by three organizations—The Alliance for Continuing Medical Education, the Society for Academic Continuing Medical Education,

and the Council on CME of the Association for Hospital Medical Education. The Alliance and SACME support it through membership dues. AHME provides an annual grant to support the journal. Each organization sends two members to serve on the Administrative Board. John Parboosingh and Richard Bakemeier represent SACME. Robert Kristofco and I represent the Alliance. Martyn Hotvedt and Brian Little represent AHME. The Administrative Board holds fiduciary responsibility for the journal and works with the publisher, BC Decker, on policy and management-related issues.

Remember, the *Journal of Continuing Education in the Health Professions* is ours, and it offers opportunities to share our knowledge, wisdom and ideas with colleagues in North America and around the world. As a SACME member, think about using it to report the research and ideas written by you and your colleagues. Do not hesitate to contact any member of the editorial group or Administrative Board with your suggestions.



*BC Decker Inc., the publisher of The Journal of Continuing Education in the Health Professions, gives an annual prize for the best research article published in the journal. The winners were recognized at the Spring SACME meeting in Charleston. They are shown holding their award, from left, Jill Donahue, H.Ba., Jane Tipping, M.A.Ed., and Eileen Hannah, M.Ed. Mark Bettiol (center) from BC Decker and Joan Sargeant, M.Ed. (right) presented the prize.*

# **BEST PRACTICES**

## **CME COURSE DIRECTOR'S CERTIFICATION TRAINING: AN INTERNET-BASED CME ACCREDITED ACTIVITY**

By Harold A. Kessler, M.D.<sup>1</sup> and Meryl Haber, M.D.<sup>2</sup>

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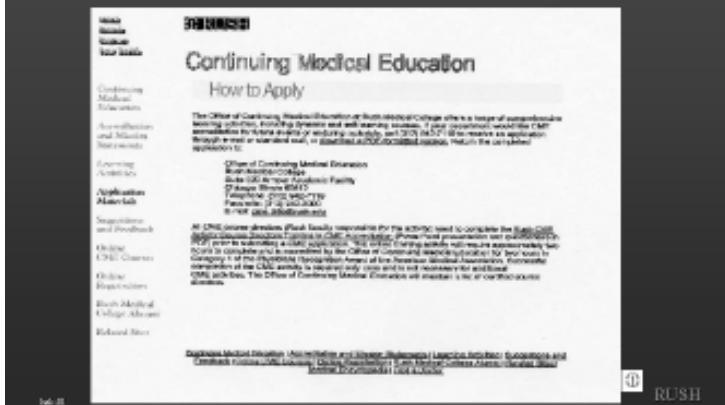
As directors of Continuing Medical Education (CME) programs we have a responsibility to assure that the conduct of our sponsored activities conforms to the Essentials and Standards of the ACCME. In our program, we require that a Rush faculty member is either the CME course director (preferable) or a member of the faculty of the sponsored activity. As it is not physically possible for the program director or a member of the CME Advisory Committee to be present at each of our sponsored activities, we depend upon our course directors to be our surrogates in assuring the proper conduct of the activity.

The responsibility for the education of our faculty about these requirements is ours as program directors. We include as part of our application packet a copy of the Standards for Commercial Support, and require a signed attestation in the application that the course director has read, understood and agrees to abide by their content. Although we have not questioned the veracity of our faculty, there has been concern that they view this requirement as a meaningless, bureaucratic, and time-wasting exercise. Occasional deficiencies in the conduct of some activities supported our concerns that not all course directors have a clear understanding of the "rules and regulations," or the importance to our program of complying with all aspects of the requirements. Therefore, we identified a need for the development of a means to fully educate our CME course directors on the basic essential elements of CME.

We identified a number of means by which we could accomplish our goal: (1) Provide additional written materials with the application packet and continue to rely upon a written attestation as to completion and compliance. (2) Schedule one-on-one training sessions with the CME program director or staff members. (3) Schedule group educational seminars. (4) Develop a self-learning activity with an outcome measure.

Given our experience with the current written materials included in the application packet, it seemed unlikely that providing additional "unstructured" written materials would improve course director compliance. One-on-one training sessions with a structured "curriculum" would assure that the course director was introduced to all the required materials, but is an inefficient utilization of CME staff and course director's time, given the anticipated problems in scheduling the training sessions. Group educational seminars are certainly more efficient for CME staff, but this alternative is problematic with regard to the timing and number of sessions offered throughout the year. Given the above limitations, we opted to develop an Internet-based, CME accredited (2 hours Category 1) self-learning activity, accessed through our CME web site ([www.rush.edu/cme](http://www.rush.edu/cme)). In addition, we adopted a new policy as of January 1, 2001, that requires course directors of any CME-sponsored activity to be "certified" by completing the course materials and successfully passing a post-activity written test.

The course is designed as a PowerPoint® presentation formatted as a *pdf* document. To access the activity, the participant needs a computer with Adobe Acrobat™ Reader or other application that allows for the opening of a *pdf* document. Hard copy of the activity is provided to individuals who cannot access the document through their computer. The activity is presented as 68 slides organized in the following sections: Purpose and Objectives, CME Accreditation and Description, Course Faculty, Faculty Disclosure, Definition and Purpose of CME, ACCME Essential Areas and Their Elements, ACCME Standards for Commercial Support, Hypothetical Questions and Answers, Course Director/Moderator's Responsibilities, How to Apply for a Rush Accredited Activity, Other Services Provided by the Office of Continuing Medical Education, How to Obtain CME Credit for This Activity, and Post-Activity Test.



The Standards for Commercial Support are presented in their entirety. The Hypothetical Questions and Answers section contains 22 scenarios relating directly to the Standards for Commercial Support. Several examples are presented as follow:

## Question 1

***What's wrong with an accredited sponsor selecting a speaker from a "speaker's list" provided by a company, if the sponsor has an identified need for a speaker on that particular subject?***

### Answer

*When the sponsor has identified the need for a particular topic, the sponsor can seek information from one or more sources, including commercial companies, about appropriate speakers for the identified need. However, the initiative should not come from a company representative or third party agency which presents a list of speakers and asks the sponsor to "pick one". Input from multiple sources will contribute to objectivity and balance.*

## Question 2

***Is it appropriate for a representative of the company that is supporting a CME activity through an educational grant to pick up the faculty member(s) at the airport, take them out to dinner, etc.?***

### Answer

*Generally, no. If the company representative establishes a relationship with a speaker, that speaker then may have some sense of obligation toward the company rather than toward the accredited sponsor that is presenting the CME activity.*

## Question 3

***What must an accredited sponsor do to assure that a CME activity is free of commercial bias?***

### Answer

*The sponsor must maintain complete control over all aspects of the educational planning and implementation process, including selection of topics and speakers and control of funding. The likelihood of a biased presentation will be greatly minimized because the Program Director and/or the sponsor's planning committee will be "in control" of all aspects of the activity.*

The Course Director/Moderator's Responsibilities section presents the required activities of the moderator for the onsite conduct of the meeting. It includes all statements that should be read prior to the activity, such as a brief overview of the activity, objectives, CME accreditation statement, faculty disclosure information, disclosure of sources of any unrestricted educational grants, registration procedures to assure that attendees will receive their appropriate CME credits, and request for completion of the activity evaluation form. In addition, a brief set of guidelines on how to moderate a successful meeting is included.

To date, 35 Rush faculty and one non-faculty participant have successfully completed the post-activity test. The evaluations of the activity have been favorable. The only problem reported by several participants has been difficulty in opening the pdf document. These individuals were provided a hard copy of the activity. A non-Rush specific generic version of the course is being developed and should be available on the web site July 1. The fee for the CME certificate will be \$25.

This CME Course Director's Certification Training activity has been an efficient and low cost means of facilitating and documenting the training of our faculty in the basic elements of an accredited CME activity. The overall effect on the outcomes of our CME-sponsored activities is as yet undetermined. The main benefit to date has been the establishment of a uniform means of assuring that all of our CME-sponsored activities are being conducted in accordance with the policies and procedures of our Office of Continuing Medical Education.

# SACME RESEARCH ENDOWMENT GRANT PROGRAM

By Jack Kues, Ph.D.

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The SACME Research Endowment Council has been helping to promote research among Society members almost from the Society's inception. Interest on the donor-restricted funds has been used over the years to directly fund research and to support research training through fellowships and a variety of special programs. The majority of these funds have been used to support a strong research grant program that has awarded almost \$170,000 in the past seven years. This current fiscal year alone the Research Endowment Council will be providing \$44,000 in direct research support.

The grant program itself has not changed substantially over the years. Small grants, up to \$5,000, are available annually. Named the New Investigator Award, this program has traditionally targeted new researchers in an effort to allow them to "get their feet wet." More experienced researchers, who are conducting pilot projects in preparation for submitting larger grant proposals, are also candidates for these small grants. A larger grant program, which funds research projects up to \$20,000, has been temporarily suspended strictly as an economic decision brought about by the decreased revenue generated by the endowment funds due to the current economy.

The most recent addition to the Research Endowment Council grant program is the Manning Award. This grant is named for Phil Manning, M.D., who was influential in defining the role of CME research when the Society began and served as the Society's first president. He has continued to promote applied CME research and the focus of this award carries on that tradition. One Manning Award is made available every two years up to \$50,000. The first Manning Award was given to Yvonne Coyle, M.D. (University of Texas, Southwestern Medical Center). Her project is currently in its second year of funding.

The Manning Award represents a maturing commitment to research within the Society and the Endowment Council. It more than doubles the size of previous grant awards and in so doing recognizes the need to support major research projects within CME. While Manning Award applicants must demonstrate collaboration with a SACME member, the principal investigator is not required to be a member of SACME.

The Endowment Council grant application and review cycle typically sets Spring deadlines. The RFPs can be found on the SACME Web site: [www.sacme.org](http://www.sacme.org). The length of proposals corresponds to the size of the awards. Small grants are limited to 10 pages including title page, references, budget and attachments. The Manning Award is reviewed in a two-step process in which applicants submit a two-page Letter of Intent. After review, successful candidates are asked to submit full proposals.

Endowment Council members serve as grant reviewers for all grant applications. A tradition of constructive feedback has been established that typically goes well beyond the feedback provided by other research funding organizations. In some cases, the council has appointed members to contact the investigators and to work with them to improve their research proposals. Other investigators have been encouraged to attend the Summer Research Institute or other research training seminars offered as part of SACME meetings. Over the years there have been relatively few outright rejections of research proposals. Many researchers have been asked to make specific changes and to resubmit their proposals in subsequent grant cycles.

The Endowment Council is interested in the impact of the grant program. At the Fall meeting of the council, members discussed presentations and publications that have come about as a result of these grants. During the next year the Endowment Council will be following up with previous grant recipients to determine the number of presentations, publications, and additional grant projects that were the product of funded projects.

Although the Endowment Council cannot guarantee that everyone who wants to conduct research will get a proposal funded, each member of the Endowment Council is dedicated to helping members improve their research skills and to turn a good research question into a solid proposal. We strongly encourage anyone interested in pursuing research to consider applying for a grant through the Endowment Council.

# AAFP LAUNCHES NEW CRITERIA FOR CLINICAL CONTENT IN CME: EVIDENCE-BASED CME CREDIT NOW AN OPTION

By Nancy Davis, Ph.D.

Director, Division of Continuing Medical Education, American Academy of Family Physicians

## The AAFP Initiative for Evidence-Based Clinical Content in CME

January 1, 2002 marked the start of a new AAFCME accreditation initiative. In response to concerns regarding the increasing numbers of accredited offerings for complementary and alternative medicine topics, the concerns of state medical licensing boards who depend on CME to assure that their physicians are competent to practice, and the concerns of the public regarding recent reports of medical errors, the American Academy of Family Physicians (AAFP) has developed an option for approving prescribed credit for evidence-based continuing medical education (EB CME). External partners who contributed to the development of EB CME include representatives from the Accreditation Council on Continuing Medical Education, the American Board of Family Practice, the American Osteopathic Association, the American Medical Association, and the Federation of State Medical Boards.

EB CME is optional, but will provide additional value to physician learners because it will assure them that the practice recommendations made in an EB CME activity will be the result of a systematic review of all available best evidence. The ultimate goal is to ensure the validity of CME clinical content to improve medical practice and patient outcomes. There is a specific credit statement to designate EB CME.

## Not Everything Is New

Evidence-based CME hours are optional, and the AAFP will continue to approve prescribed credit for customary and generally accepted medical practice, which is defined as diagnostic and therapeutic interventions that are accepted by the practicing medical community for given indications in individual patients, families, and communities. As always, to obtain prescribed credit an AAFP member must be involved in developing the CME activity.

## Credit for Complementary and Alternative Practice

Complementary and alternative practice topics that meet requirements for EB CME will be approved for prescribed credit. Elective credit may be assigned to those topics that are neither evidence-based nor customary and generally accepted medical practice, but are not dangerous to patients. Dangerous interventions are those where risks substantially outweigh benefits to patients.

Non-clinical topics, such as practice management, teaching skills, ethical and social issues, professional development, and leadership skills, are still eligible for prescribed or elective credit with no new documentation requirements.

## Criteria for Evidence-Based CME

Providers applying for EB CME credit will be asked to list key practice recommendations that will be presented

in the activity. The recommendations must be substantiated from approved evidence-based sources in which all the trials of the topic have been systematically identified, appraised, and summarized according to predetermined criteria. The current approved list of sources includes:

- **Agency for Healthcare Research and Quality Clinical Guidelines and Evidence Reports (AHRQ)** ([www.ahrq.gov/clinic/](http://www.ahrq.gov/clinic/))
- **Bandolier** ([www.jr2.ox.ac.uk/Bandolier/](http://www.jr2.ox.ac.uk/Bandolier/))
- **Clinical Evidence, BMJ Publishing Group** ([www.clinicalevidence.org](http://www.clinicalevidence.org))
- **Cochrane Database of Systematic Reviews** ([www.cochrane.org/](http://www.cochrane.org/))
- **Database of Abstracts of Reviews of Effectiveness (DARE)** ([www.agatha.york.ac.uk/darehp.htm](http://www.agatha.york.ac.uk/darehp.htm))
- **Effective Health Care** ([www.york.ac.uk/inst/crd/ehcb.htm](http://www.york.ac.uk/inst/crd/ehcb.htm))
- **Evidence-Based Medical Journal** ([www.acponline.org/journals/ebm/pastiss/htm?idx](http://www.acponline.org/journals/ebm/pastiss/htm?idx))
- **Evidence-Based Practice Newsletter** ([www.ebponline.net](http://www.ebponline.net))
- **Institute for Clinical Systems Improvement (ICSI)** ([www.ICSInet.org](http://www.ICSInet.org))
- **Medical InfoRetriever** ([www.medicalinforetriever.com/](http://www.medicalinforetriever.com/))

CME faculty will be required to disclose their sources of evidence and are highly encouraged to describe the level of evidence for the recommendations they make. Evidence from meta-analyses of

randomized control trials is considered to be the highest level followed by evidence from cohort studies and retrospective case studies. Various grading schemes included in the pilot phase of the evidence-based CME initiative have been eliminated.

### **Challenges of Evidence-Based CME**

As in the practice of medicine, there are challenges for integrating EBM into CME. For some topics, there may be no reviewed evidence available. These topics will not be eligible for evidence-based CME credit, but should not be excluded from CME programming. In some cases there will be conflicting evidence. That is why planners should always utilize content experts as CME faculty. Faculty will use their expertise to evaluate best available evidence and present it from their own perspective as practicing physicians or scientists. Additionally, physician learners must use

their own critical thinking skills to determine what is in the best interest of their patients.

### **Support for CME Providers**

SACME members are encouraged to integrate evidence-based CME into their programming. A number of resources are available for providers and CME faculty who need assistance. A web-based training module will soon be available on the AAFP website, [www.aafp.org/cme/accreditation](http://www.aafp.org/cme/accreditation). AAFP staff and members of the AAFP Commission on CME (the body that has oversight on CME policy at the AAFP), are available to present at meetings of CME providers and faculty.

### **Measuring Impact of Evidence-Based CME**

AAFP's next priority is conducting outcomes studies to measure the impact

of evidence-based CME. A group of interested providers is working to determine how best to approach the study. If you are interested in participating in a study, please contact Nancy Davis as listed below.

### **For More Information**

For more information about the AAFP's initiative on evidence-based CME or to share comments or concerns, please contact Nancy Davis, Ph.D., Director, Division of CME, AAFP, at (913) 906-6000, Ext. 6510, or [ndavis@aafp.org](mailto:ndavis@aafp.org).

For more information about the AAFP accreditation process, contact David Baldwin, Manager, CME Accreditation, AAFP, at (913) 906-6000, Ext 6540, or [dbaldwin@aafp.org](mailto:dbaldwin@aafp.org). Information can also be found on the AAFP Web site at [www.aafp.org/cme/accreditation](http://www.aafp.org/cme/accreditation).

## **NEWS FROM THE AMERICAN MEDICAL ASSOCIATION**

By Dennis K. Wentz, M.D. and Charles Willis, M.B.A.  
Division of Continuing Physician Professional Development

Our Division hopes all of you are doing well as we prepare for the summer months. Meeting with other SACME members at the Charleston conference in April was, as usual, both thought-provoking and a pleasure. I am pleased that Charles Willis, our new Director of the AMA PRA Program, was able to be there (and even drum up some interest for the AMA Performance Improvement Pilot Project). After our Winter 2002 column that digressed into AMA's new Declaration of Professional Responsibility, I would like to

get back to some CME issues that are being discussed within our unit.

### **Journal Peer Review for CME Credit**

In recent months, two medical societies approached the AMA to consider allowing providers the privilege of designating physician work in reviewing journal articles (peer review) for AMA PRA category 1 credit. Both the American Institute of Ultrasound in Medicine and the Radiological Society of North America (RSNA) submitted such requests.

Current AMA PRA rules and CPPD's standard response do not create a "carve out" in the longstanding rules for this activity in order for providers to designate peer review work for Category 1 credit. We took the issue forward to the AMA Council on Medical Education for their input and direction. The Council reaffirmed our staff position because, in their view, a content expert generally ends up doing the peer review (offering little incentive for new knowledge acquisition) and the process does not usually involve interaction among the participant physicians.

What brought this issue to mind was one of the slides, from the spring meeting, in Dr. David Slawson's wonderful presentation, "Information Mastery: Evidence-Based Medicine in Everyday

Practice.” Dr. Slawson argued that to get POEMs (Patient Oriented, Evidence based and Medically relevant nuggets of information), physicians needed to both hunt and forage in the clinical literature. On his “hunting slide”, Dr. Slawson stated that “More expertise = stronger opinion, less time spent on review, lower quality (Guess who does most CME talks?)” [Oxman AD, Guatt GH. The science of reviewing research. *Ann NY Acad Sci* 1993; 703:125-33]. To which we can only add in defense of the AMA decision: guess who does most journal article reviews? But it seems likely that a resolution asking for reconsideration will be submitted at the AMA Annual meeting in June. What is your opinion?

## Test Question Preparation for CME Credit

In response to a proposal by the American College of Obstetricians and Gynecologists (ACOG), which asked the AMA to consider specific forms of test question preparation as eligible for AMA PRA category 1 credit, we will convene a small group of interested stakeholders (including the National Board of Medical Examiners and a Specialty Board) to thoroughly vet this concept.

We assume that some learning occurs, but expect to look closely at both content and process to determine how much “knowledge gain” derives from writing test questions. We will need to assess whether learning is incidental to the process and whether physicians are pushed to develop questions at the boundaries of their expertise (thus forcing them to learn new

material). Or, does the cognitive sharpening and new learning take place during open debate with colleagues, e.g. when test question writers must defend their submissions. Many test-writing organizations will have a keen interest in the outcome of this discussion and perhaps some SACME members – we will keep you posted.

## Remedial CME, an Oxymoron?

An issue that has come up before, never went away, and which may be heating up again, is whether remedial education for physicians having sanctions to their medical licenses should ever be designated for AMA PRA category 1 credit. For years the Coalition for Physician Enhancement (CPE) has examined this and related issues, in the context of identifying assessment strategies that lead to successful remediation. Since all CME should improve performance, then why should credit be denied for activities which, if successful, will help a physician regain or retain his or her license?

From the perspective of the AMA PRA credit system, the question narrows considerably. To be eligible for an AMA PRA certificate, a physician must be licensed and in good standing with the relevant authorities. The AMA PRA rules are less clear for an accredited provider who designates an activity for Category 1 credit (say, training in professional ethics) that targets physicians who have been unambiguously directed by their medical board to get such education. Nothing in our current AMA PRA rules specifically precludes such education; however, the philosophical question remains: should

physicians receive Category 1 credit for education that helps them overcome ethical lacunae (an area they ought to have been grounded in before receiving their first full and unrestricted license)?

Our answer for the moment is a guarded “yes,” as long as providers also rigorously comply with all the other AMA PRA requirements for designating an activity for Category 1 credit. However, the issue is far from settled and CPPD, in consultation with CPE and others, may look to develop new recommendations on this topic for consideration by the Council on Medical Education.

## “The Continuing Professional Development of the Physician: From Research to Practice”

If you were in Charleston, you perhaps received the flier that the book, “The Continuing Professional Development of the Physician: From Research to Practice” is nearing publication and AMA Press should have it in distribution by early this Fall. I cannot thank enough those SACME colleagues who contributed their time to editing and writing chapters for this book. CME and CPPD have evolved and continue to evolve—your efforts document where we have been and where we are headed. Finally, I would like to thank our three editors for steadfastly seeing the project through, Drs. David Davis, Barbara Barnes and Robert Fox. The book will be published by the time SACME next meets at the AAMC Fall meeting in San Francisco. Time for a party?

The SACME Board of Directors gratefully acknowledges an unrestricted educational grant received from [CMEinfo.com](http://CMEinfo.com) in support of this issue of *Intercom*.



**CMEinfo.com**

## UPCOMING EVENTS

June 23-25, 2002

Global Alliance for Medical Education

7<sup>th</sup> Annual Meeting

“How Physicians Learn Around the World”

Montreal, Quebec, Canada

Contact: Celene Chasen (713) 798-4024

July 26-27, 2002

CME: The Basics

Chicago, Illinois

Web site: [www.acme-assn.org](http://www.acme-assn.org)

July 28-29, 2002

Understanding ACCME Accreditation

Presented by Accreditation Council for Continuing Medical Education

Chicago, Illinois

Contact: Sandra Benitez (312) 464-2500

September 10-12, 2002

13<sup>th</sup> Annual Conference of the National Task Force on CME Provider/Industry Collaboration

“Changing CME from Silos to Synergies: A Collaborative Vision and Mission”

Baltimore, Maryland

Contact: Regina Littleton (312) 464-4637

September 21-24, 2002

“CME Leadership in the 21<sup>st</sup> Century: A Case-Based Conference for Current and Future Leaders in Continuing Medical Education”

Sponsored by Duke University Office of Continuing Medical Education and Professional Postgraduate Services<sup>®</sup>

Durham, North Carolina

Contact: (800) 222-9984

October 12-13, 2002

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

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

Madison, Wisconsin

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

October 16-19, 2002

International Conference on Physician Health

“Physician Health: Self, Service, Leadership”

Sponsored by the AMA and the Canadian Medical Association

Vancouver, BC, Canada

Contact: Roger Brown, Ph.D. (312) 464-5476 or [roger\\_brown@ama-assn.org](mailto:roger_brown@ama-assn.org).

November 8-13, 2002

SACME Fall Meeting

Association of American Medical Colleges

San Francisco, California

Contact: Jim Ranieri (205) 978-7990

January 29-February 1, 2003

2003 Alliance for CME Annual Conference

Dallas, Texas

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