The Society for Academic Continuing Medical Education

INTERCOM

THE SOCIETY FOR ACADEMIC CONTINUING MEDICAL EDUCATION

Spring 2003 Meeting Highlights

Santa Fe, New Mexico - April 2-6, 2003

By Melinda Steele, M.Ed., Program Committee Chair

Photographs by Laurence A. Cole, Ph.D., Department of Obstetrics and Gynecology, University of New Mexico-School of Medicine, Albuquerque, New Mexico

The Program Committee has been extremely busy planning the Spring meeting. It seems there are always more topics than time available to cover them in one meeting, a nice problem to have in some respects.

Current issues in CME include finding ways to implement the new vision(s) for CME that are coming at us from multiple directions. There are also various sources pressuring CME to be more visible in the area of accountability. With this in mind, an aggressive agenda has been set. The theme for the meeting is "Aiming Higher: Competency and Quality in Academic CME."

All of Wednesday and much of Thursday morning will be dedicated to Society business including the Board meeting and committee meetings. Thursday afternoon's opening plenary will deal with ways of implementing the new vision for CME. Many articles have appeared in the media recently that are critical of CME and commercial support issues, as well as other areas tangentially related to CME. It has been suggested that we take the criticism received in such articles, the issues raised in our new visions discussion in the Fall, and examples from other CME groups, such as specialty societies, and blend these into a proposal for action. In addition to formal presentations, time has been built in for interactive small group discussions on this topic.

On Friday, the topic will be centered around the core competencies across the continuum. There will be both formal presentations and small group discussion on this topic.

For the last hour of the morning on Friday before the free time/ optional workshop, Bob Kristofco, M.S.W. will give a thought-provoking presentation he gave at the Texas Medical Association meeting last summer. This session will be relevant as well as fun, promising to provide some lighter moments.

The Friday afternoon optional workshop, "Tools and Resources for Competency and Quality in Academic CME" will deal with knowledge management and technology that can be applied to research areas, office management, or any other need.

Most of Saturday will be devoted to best practices and RICME. The business meeting will be held during lunch and has been expanded to include a "presidential address" at the request of Society leadership. With so many diverse hot topics at hand, a two-hour block in the afternoon has been set aside for those issues. In this session Dennis Wentz, M.D. will provide additional information from the American Medical Association on international CME, discussion will occur on AAMC Group on Educational Affairs issues, as well as other topics that will be plugged in as they arise.

Registration information and hotel information can be found on the SACME web site at http://www.sacme.org. Make your hotel reservations soon to take advantage of the conference rates. We look forward to seeing you in Santa Fe!

For schedule and program details, see page 5.

In This Issue

From the President

By Jack Kues, Ph.D.

"How many legs does a dog have if you call the tail a leg? Four. Calling a tail a leg doesn't make it a leg."
- Abraham Lincoln

Both the popular press and our professional colleagues have been calling attention to the amount of pharmaceutical company money that has supported continuing medical education. The 2002 SACME survey of medical schools reported that over the past eight years, commercial support of CME programs has increased five-fold. This is the largest increase of medical schools' overall CME budgets. The typical medical school generates almost half of its revenues from commercial support. This is a disturbing trend but it does not mean that medical schools are operating biased programs. It does, however, raise an important question about how CME should be funded. While the debate rages over exactly how much influence commercial supporters have over CME programming, the fact remains that hundreds of millions of dollars are being expended by pharmaceutical companies annually in support of informing practicing physicians about new and better treatments for various diseases and conditions. It would be naïve of us to believe that pharmaceutical companies are completely altruistic in their intentions.

The public is becoming increasingly weary of insider deals, kickbacks, and influence peddling in all areas of our lives. As CME providers we are keepers of that public trust. There is an expectation from physicians and their patients that we develop CME programs that result in better patient care without regard to special interests. Over the years I have fought to keep out the obvious biases from company logos on slides and trade names embedded in activity titles or the covers of enduring materials. I have gone out of my way to find speakers with opposing views so that my programs are "balanced." I have congratulated myself for meticulously reviewing the backgrounds and potential conflicts of interest of our speakers. In the midst of trying to be a good steward of the public trust I have also watched the percent of commercial support for my program budget creep higher every year. I recognize that I cannot operate my CME office without this support and I console myself that this is a necessary compromise in order to continue the quality programming that I offer to practicing physicians. The institutional support is just not there and no alternative funding sources have made themselves obvious.

I am not sure that the constituents (physicians or their patients) would agree that the compromise that I am making is necessarily a good one. The press and other public interest groups are connecting money spent on dinners, pens, pads, and other gifts to the cost of their prescription medications. The Bush administration is considering a plan to restrict gifts to physicians to encourage the prescribing of particular drugs. This is consistent with the general stance taken by the American Medical Association and the Pharmaeutical Research and Manufacturers of America but there has been considerable criticism of the federal proposal from physicians, pharmaceutical companies, and the above mentioned organizations according to a recent *New York Times* article. The article suggests that these payments are "embedded in the structure of the health care industry" and their removal would be "profoundly disruptive." I have no doubt that these things are true but I do not believe that the general public will be reassured. The pharmaceutical industry exists in a competitive market similar to that of soft drinks and automobiles. They have products and a customer base that they are trying to influence. Marketing is integral to all industries and it is highly effective. Continuing medical education is an important part of marketing strategies and it is important that we recognize that.

We are currently facing two challenges: the accomplishment of our educational mission, and the continued existence of our operations. These are very distinct, but interrelated, issues and must be addressed independently. Over the past several years several individuals and groups have formulated visions of a new CME. While there are some differences, most vision statements have focused on the need to develop self-assessment tools for physicians, move CME into the practice

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environment, and shift to measures of competence to help direct education and practice changes. Multidisciplinary groups of physicians will learn from each other in communities of practice with the goal of improving the quality of patient care. Information technology and evidence-based resources will be keystones of this new model of continuing professional development. Several institutions have been experimenting with pieces of this new model and I anticipate a steady shift in this direction over the next couple of years. I do not have a clear picture of what this new CME will look like but it will unquestionably require substantial resources to develop and maintain.

The continued existence of our CME operations is a more fundamental challenge for us. A significant shift in the model for CME will require us to reassess our current organization and staff. For offices organized around traditional meeting planning activities, a failure to change could be fatal. At some point the issue of commercial support for base operations funds will need to be addressed. A sudden reduction or elimination of these funds will substantially change a CME operation unless alternative funds are quickly found. Additionally, the shift to a more individualized practice-based CME model does not fit very neatly into the current commercial support model. In either situation the ethical issues and desirability of large amounts of commercial support need to be addressed. As a profession, we will need to seek additional sources of funding from our own institutions, the physicians who attend our programs, and external sources such as grants and contracts.

In the end, we must admit that CME is changing significantly. Despite our best efforts we are falling short of what we are trying to do and who we are trying to be. The education of practicing physicians is more critical now than ever before. Others are finally recognizing what we have known for many years. We have many more potential allies and partners for moving closer to the vision that others have laid before us. We have a great deal to be proud of, but we have much more that we need to accomplish.

Highlights from SACME 2002 Fall Meeting

The SACME Fall meeting, held November 8-11, 2002 in San Francisco, California in conjunction with the meeting of the Association of American Medical Colleges was attended by 95 people, had a full agenda, and covered many hot and/or emerging issues. Kudos to Melinda Steele, M.Ed. (chair) and members of the Program Committee for creating a stimulating and thought-provoking program. The article on page 4 by Nancy Davis, Ph.D., summarizes the content of the opening plenary session that focused on the new visions for CME.

Top right: Despite long hours and hard work, SACME members had an opportunity to network and relax at the Society reception. Seated from left are John Boothby, M.S.W., Nancy Davis, Ph.D., Melinda Steele, M.Ed., Susan Duncan, M.Ed., Gloria Allington, M.S.Ed., and Jack Kues, Ph.D.

Bottom right: A "robing" ceremony was held at the Society Business Breakfast for Jocelyn Lockyer, Ph.D., who received her doctorate degree from the University of Calgary in adult community and higher education. Dr. Lockyer missed her own robing ceremony in order to attend the SACME Fall meeting. Barbara Barnes, M.D. assists Jack Kues, Ph.D. in robing Dr. Lockyer, using "borrowed" hotel robes, as Nancy Davis, Ph.D., looks on.

New Vision for the Professional Development of Physicians Revisited at Fall Meeting

By Nancy Davis, Ph.D.

The opening plenary session at the SACME Fall meeting in San Francisco in November 2002 focused on a review and update of the new visions for CME with three presentations. Linda Casebeer, Ph.D., Associate Director of CME, University of Alabama-Birmingham, presented an update of professional development for physicians as a follow-up to the seminal paper, "Continuing Medical Education: A New Vision of the Professional Development of Physicians," by Nancy Bennett, Ph.D. and colleagues that was published in *Academic Medicine* in December 2000.

Dr. Casebeer outlined the charge of CME to effectively assist physicians in knowledge generation, translation, diffusion, appraisal, and use in order to improve the quality, compassion and cost-sensitivity of patient care. Enacting the new vision requires research in how physicians learn and change; promoting systematic learning from clinical experience; providing resources to expand learning skills; linking data with educational systems; establishing relationships across the educational continuum; collaborating to measure learning; and maintaining CME educators' competence.

Dr. Casebeer cited several examples of how to translate the new vision to practice including SACME activities such as promotion of research in CME; best practices as RICME sessions; collaboration with AAMC activities such as RIME; and teaching research skills to CME professionals. Additionally, the Agency for Healthcare Quality and Research (AHRQ) is fostering the new vision by promoting translation of research into practice and awarding grants to evaluate the effectiveness of various interventions in improving physicians' performance and patient health outcomes.

Ronald Franks, M.D., Dean, James H. Quillen College of Medicine, East Tennessee State University, and Chair of ACCME, addressed assessment of individual learning needs of physicians; utilization of diverse educational approaches; and the measure of impact on patient care. He indicated there are gaps between the vision and the real world of CME. Dr. Franks charged the audience to recognize needs in knowledge, skills and attitudes of physicians by using innovative assessments such as comparing practice patterns; conducting computer searches to answer patient care questions and patient questions; reading journal articles; and analyzing malpractice patterns. He encouraged use of more interactive educational approaches such as "just in time" learning; case-based small group discussions; simulators; and formal testing of acquired knowledge/skills.

Finally, Dr. Franks urged CME providers to measure impact of their activities on patient care through analysis of QI reporting; morbidity and mortality data; chart reviews; and patient surveys. While there are imperatives for change such as the Institute of Medicine's recent reports, there are also barriers to change including a credit hour system that does not fit well with new types of delivery and a question of how new innovations in CME will be funded. Dr. Franks concluded by stating that while there is still much to be done, the gap is closing.

Finally, Norman Kahn, Jr., M.D., Vice President of Science and Education, American Academy of Family Physicians, reported on the new position paper, "Repositioning for the Future of CME," developed by the Council of Medical Specialty Societies (CMSS). The paper, which can be found at the CMSS website (www.cmss.org), puts forth 16 recommendations for repositioning CME to prepare for the future, including defining core curriculum for CME content; incorporating core physician competencies; evidence-based content; decreasing the burden of tracking CME activities; elimination of inappropriate bias; facilitating skills development for CME educators; and engaging all stakeholders in the repositioning of CME. Dr. Kahn reviewed each of the recommendations and discussed which stakeholders would need to be involved to effect change. For example, definition of core curriculum for content is the responsibility of specialty societies and their certifying boards in each specialty. Many of the recommendations will require collaboration and innovation on the part of CME providers, faculty, regulators, and other CME stakeholders.

In summary, Dr. Kahn quoted from the repositioning document, "By adopting these recommendations, CME will be repositioned to be more effective and more widely integrated into physician practice performance, and thereby contribute to further improvements in the care being delivered to the public."

This session served to energize the audience. It validated the new visions and gave examples of how the CME enterprise is meeting the challenges to improve the professional development of physicians. Further, it brought to light the similar goals of SACME and the CMSS. Discussions are underway to determine how the CME directors of CMSS and SACME might collaborate to meet common goals.

Spring 2003 Program Overview
Aiming Higher: Competency and Quality in Academic CME

Wednesday, April 2, 2003

9:00 am – 3:00 pm	Board Meeting
3:30 – 4:30 pm	Program Committee
4:30 – 5:30 pm	Finance Committee
6:00 pm	Tri-Group

Thursday, April 3, 2003

7:00 – 9:00 am	Research Endowment Council
8:00 – 9:00 am	Membership Committee
9:00 – 11:00 am	Research Committee
11:00 am – Noon	Society Meeting Planning Group
1:00 – 5:00 pm	Opening Session
1:00 – 1:15 pm	Opening Remarks *Jack R. Kues, Ph.D.*
1:15 – 3:00 pm	Plenary Session: Implementing the New Visions for CME *Moderator: Jack R. Kues, Ph.D.* • CME Plus *Murray Kopelow, M.D.* • Is the Vision Still the Same? The Current State of the Vision *Nancy Bennett, Ph.D.* • An Operational Model from American Academy of Pediatrics *Suzanne Ziemnik, M.Ed.* • The Grand Experiment *Jack R. Kues, Ph.D.*
3:00 – 3:30 pm	Break and Exhibits
3:30 – 4:30 pm	Small Group Discussions
4:30 – 5:30 pm	Small Group Presentations and Panel Q&A
5:30 pm	New Member Orientation
6:00 – 9:00 pm	Special Evening at the Museum of International Folk Art

Friday, April 4, 2003

6:45 – 8:00 am	Regional Breakfast Meetings
8:00 am – Noon	Educational Session *Moderator: Melinda Steele, M.Ed.*
8:00 – 8:15 am	Introductions and Preliminary Remarks
8:15 – 9:45 am	Implementing the Core Competencies Across the Continuum
8:15 – 8:45 am	Example Models *Craig Campbell, M.D., Ellen Cosgrove, M.D., Joseph Green, Ph.D., and Paul Mazmanian, Ph.D.*
8:45 – 9:45 am	Small Group Discussion
9:45 – 10:15 am	Break and Exhibits
10:15 – 11:00 am	Small Group Presentations and Panel Q&A
11:00 am – Noon	A Surprise on the Lighter Side of CME *Robert Kristofco, M.S.W.*
1:30 – 4:00 pm	Optional Workshop: Tools & Resources for Competency & Quality in Academic CME *Jack R. Kues, Ph.D. and Anne Taylor-Vaisey, M.L.S.*

Saturday, April 5, 2003

6:45 – 7:30 am	Continental Breakfast
7:30 – 11:30 am	Educational Session *Moderators: Joan Sargeant, M.Ed. and Michael Allen, M.D.*
7:30 – 9:30 am	RICME
9:30 – 9:45 am	Break and Exhibits
9:45 – 11:30 am	Best Practices
11:30 am – 1:30 pm	Lunch/Business Meeting/Awards
1:30 – 5:00 pm	Educational Session *Moderators: Joan Sargeant, M.Ed. and Michael Allen, M.D.*
1:30 – 2:15 pm	RICME/Best Practices (Continued)
2:15 – 2:30 pm	Break and Exhibits
2:30 – 4:30 pm	Trends and Issues (aka Hot Topics) *Moderator: Nancy Davis, Ph.D.*
4:30 – 4:45 pm	Closing

Sunday, April 6, 2003

7:00 – 9:30 am	Town Meeting and Continental Breakfast

BEST PRACTICES

CREATING A PRIVACY STATEMENT FOR INTERNET CME ACTIVITIES

By R. Van Harrison, Ph.D. and Pierre A. Lavalard, M.B.A.
Office of Continuing Medical Education, University of Michigan Medical School

ACCME's new policy on Internet CME activities requires that effective October 1, 2002 accredited providers "have, adhere to, and inform the learner about its policy on privacy and confidentiality that relates to the CME activities it provides on the Internet" [www.accme.org/whatsnew/sec_new_nw1_227.asp]. Since limited information was available concerning the need for this requirement or how to meet it, we checked several sources for information regarding general principles and specific operational issues. We determined that no one statement will work for every CME provider. In fact, a CME provider may need different privacy policies for different Internet CME activities. Therefore, understanding some principles and operational issues can help enormously in deciding what is appropriate for your Internet CME site.

Underlying Concerns

CME providers have been collecting information in written form from participants for decades, but no privacy policy has been required. Why is there a special requirement for the Internet? The potential for inappropriate or unauthorized use of information and behavior is much greater when individuals use the Internet. Individual use can be tracked, information about the user from several sources can be linked, information can be easily transferred or sold, and users can be subsequently contacted electronically at little expense.

Medically related sources address the potential for electronic information to be abused.

• AMA Guidelines. The AMA has Guidelines for Medical and Health Information Sites on the Internet [www.ama-assn.org/ama/pub/category/1905.html]. Pages 7-9 address "principles for website privacy and confidentiality."
• Internet Healthcare Coalition. This group has developed an eHealth Code of Ethics [www.ihealthcoalition.org/ethics/code0524.pdf]. Page 6 has a short section concerning principles related to privacy.

Both sources provide insight into general issues. However, neither provides operational guidance.

Operational Information

Content. What specific points may be addressed in a privacy statement? After conducting several Internet searches, we felt that the Online Privacy Alliance [www.privacyalliance.org] had a particularly useful set of information. More than 40 global companies and associations founded this organization to promote trust and protection of individuals' privacy online and in electronic commerce. The five-page description of resources [www.privacyalliance.org/resources/] includes guidelines for online privacy policies, links to privacy policy "generators," links to enforcement programs, links to U.S. Federal Trade Commission privacy information, and other resources.

The Online Privacy Alliance's guidelines are that policy statements provide:

• Notice and disclosure
  - Be easy to find, read, and understand, and encountered prior to information collection
  - State what information is being collected and its use
  -State accountability mechanism and how to contact organization
• Choice/consent – opportunity to opt out of uses unrelated to the purpose of collection
• Data security – measures to assure security of individually identifiable information
• Data quality and access – mechanisms so that inaccuracies may be corrected

An operationally useful resource was links to online "privacy policy generators." These Internet-based tools ask step-by-step questions that address elements for a privacy policy. You provide responses about your Internet site, then these tools generate an applicable privacy policy statement. Two policy generators are:

• The Direct Marketing Association's Privacy Policy Generator [www.the-dma.org/privacy/creating.shtml]
• The Entertainment Software Rating Board's Privacy Online Statement Creator [www.esrb.org/wp_composer.asp]

For example, one question to complete is:

The information we collect is *(choose all that apply)*:

- ☐ Used for internal review and is then discarded
- ☐ Used to improve the content of our Web page
- ☐ Used to customize the content and/or layout of our page for each individual visitor
- ☐ Used to notify visitors about updates to our Web site
- ☐ Used by us to contact customers for marketing purposes
- ☐ Shared with other reputable organizations to help them contact customers
- ☐ Not shared with other organizations for commercial purposes
- ☐ Other: _____

The "policy generators" introduced us to many specific operational issues that we had not considered. However, the "policy generators" are designed for companies conducting a broad range of sales and marketing activities on the Internet with sites that may be very sophisticated. Also, the actual statements that are generated feel like a "patchwork" of sentences that are technically accurate, but difficult for a reader to follow.

Privacy policies are contracts. Privacy policies establish an agreement between the CME site operator and visitors to the site. A CME site operator's privacy policy states how the site operator will use information about site visitors. Visitors can review the policy and decide in advance whether to provide information. The policy is an "informed consent" agreement for visitors, functioning as a legal contract. If the CME site operator uses information for other purposes, visitors can sue the site operator for compensation for any "damages" that result to the visitor from unauthorized use of information.

Privacy statements may vary widely concerning the amounts of information collected and its uses. The fundamental requirement is simply that site operators make their intensions clear to the visitor.

Simple or informative? We considered the opposing philosophical approaches of creating a short, simple policy or creating a longer informative one. Consumers report that they want Internet privacy policies to be shorter and clearer [www.ecommercetimes.com/perl/story/15084.html]. However, most short policies are statements of general principles that essentially say "we promise to respect your privacy so trust us." Organizations and groups that are concerned about privacy rights generally advocate more informative policy statements that address specific operational issues in the collection, use, and sharing of information. Detailed statements provide more protection because the site makes specific operational commitments to visitors that have the potential for legal enforcement. However, an overly lengthy statement is not likely to be read and may therefore be of little immediate practical consequence.

Our own institution's policies. We searched our institution's Internet sites and asked relevant institutional personnel for information on institutional Internet privacy policy. We found statements and guidelines concerning privacy, but they were phrased generally as principles relevant to a wide range of uses of computers and electronic information. We did find a few useful operational points. For example, we found that our institution has identified a central location for complaints about abuses of privacy that could not be addressed elsewhere.

Other Internet CME sites. We looked at privacy statements of more than a dozen Internet CME providers to see if any had the "perfect" one for us simply to copy. One university site was only three sentences. Another university site was four pages. A commercial site addressed complex uses of information. None of the sites was a model that closely fit what we felt would be appropriate for our site.

Our Privacy Statements

Creating our privacy statement. We first decided on a "vision" of what we wanted our policy statement to be. Our site is fairly simple, so we decided we could be operationally informative without the statement being too long. We wanted to include references to our institution's policies and remedies so visitors would recognize their privacy was a general concern. We wanted it to be organized by topics and headings that made it easy to scan for parts of interest to an individual visitor. We wanted the language to be somewhat conversational and personal.

With this "vision" in mind we assembled the resources we had accumulated: our institution's policies, a "policy" we produced using one of the generators, and examples of policy statements from three CME sites that contained aspects that we particularly liked. We then produced a draft. Subsequent internal review produced the final wording.

Location of the privacy statement. Our last step was to decide where to place a link to our privacy statement so that visitors would most likely see it. Most visitors arrive at our CME "home" page, so we put a link to the statement there. (Go to

cme.med.umich.edu to see the link and our policy statement.) However, a large number of visitors go directly from links on other sites to a specific CME activity on our site. Therefore, we also put a link to our privacy statement on the first page of each CME activity.

Our other privacy statements. Our self-congratulations on creating our privacy statement were short-lived. We had created a privacy statement for the main Internet CME site hosted at our institution for external visitors. We soon realized that we had to develop variations of that policy statement for some of our CME activities hosted on other CME sites. Under a contract with Ford Motor Company our institution is providing a private Internet site for the CME of their company-employed occupational physicians worldwide, with CME credit available for U.S. physicians. We had to modify our privacy statement for that site to reflect practices there. For example, physicians participate as part of assigned work responsibilities and we report to the company whether or not physicians have completed a CME activity. Some of our Internet CME activities are developed with the assistance of communication companies and are hosted on their sites. We review the operations of those sites and may occasionally authorize a variation of our privacy statement that makes sense in the context of the activity.

Conclusion

ACCME's requirement for Internet CME privacy policies has introduced a new topic about which CME providers need continuing education. Privacy statements are enforceable legal contracts, so CME providers with Internet activities should have a basic understanding of the issues involved. Variations in circumstances of CME providers, CME participants, and CME activities result in no "one size fits all" solution for a privacy statement. Even a single CME provider may need to develop more than one privacy statement in order to reflect the circumstances relevant to specific Internet CME activities.

Ellen Cosgrove Elected to Chair GEA CME Section

By Joyce M. Fried

Ellen Cosgrove, M.D., Senior Associate Dean for Education at the University of New Mexico HSC School of Medicine in Albuquerque and SACME Western Region Representative, has been elected to serve as the Chair of the CME Section of the Group on Educational Affairs (GEA) of the American Association of American Medical Colleges (AAMC).

The CME Section is composed of 300 members who have been appointed by either their dean or the CEO of their teaching hospital or have requested membership. In her role, Dr. Cosgrove leads the CME Section Steering Committee and represents the CME Section on the national GEA Steering Committee that meets three times a year to consider and make recommendations to the AAMC on education policy and to plan the GEA portion of the AAMC Annual Meeting.

During her tenure as Chair, Dr. Cosgrove hopes to complete a project this year addressing the competency of practice-based learning and improvement. In addition, she would like to see the CME community take a leadership role in systems-based care. The contribution that the academic CME community can make to the other members of the GEA in applying the principles of adult learning and successful course management to the rest of the educational continuum is another priority. Finally, enhancing the role of the academic CME group in effective faculty development is another area of concentration that could prove to be important in the next few years, according to Dr. Cosgrove.

Asked what the key issues facing CME today are, Dr. Cosgrove replied, "Clearly, the current controversies surrounding the funding of CME threatens the credibility of the academic CME enterprise. This issue represents a significant area of vulnerability for all of us in the CME community.

"The role of CME within the medical school or academic medical center must move from meeting planning to strategic partnering for the other academic departments and units. The CME unit must contribute to the education of learners in the undergraduate and graduate realms as well as to improved practice in the university's hospitals and clinics. The academic CME unit has a responsibility for scholarly productivity just like any other department in an academic institution."

Dr. Cosgrove is married (for 27 years) and has two sons and a daughter. She enjoys reading history, art books, and the books her children are reading. She loves to cook and has recently learned to crochet and to knit. Her tenure as Chair of the CME Section began in November of 2002 and will continue until November of 2004.

SACME Adopts Conflict of Interest Policy

By Nancy Davis, Ph.D.

The SACME Board of Directors adopted a conflict of interest policy in September 2002. The policy is available on the SACME website (www.sacme.org).

Conflict of interest is defined as a situation where (a) a member's personal interests; or (b) those of a close friend, family member, business associate, corporation or partnership in which you hold a significant interest, employer, or a person to whom you owe an obligation could influence your decisions and impair your ability to: act in the Society's best interests; or represent the Society fairly, impartially and without bias.

It is important to note that a "conflict of interest" exists if the decision could be influenced—it is not necessary that influence takes place.

Policies Related to Conflict of Interest

The SACME policy on conflict of interest contains the following elements:

- Unless authorized to do so by the Board, or by a person the Board designates, members may not (1) act on behalf of the Society, or deal with the Society, in any matter where a member has a conflict of interest or appears to have a conflict of interest, nor (2) use a position, office or affiliation with the Society to pursue or advance personal interests.

- The "appearance of a conflict of interest" occurs when a reasonably well informed person could have a reasonable perception that a member is making decisions on behalf of the Society that promote a member's personal interests and are not consistent with the interests or goals of the Society.

Visit the SACME Web Site at www.sacme.org

- "Society information" is information that is acquired solely by reason of involvement with the Society and is considered proprietary information, disseminated only with approval of the Society Board or executives. Therefore, members (1) may use Society information only for Society purposes; (2) may not use Society information for personal benefit; (3) must protect Society information from improper disclosure; and (4) may divulge society information if (a) they are authorized by the Board or by a person designated by the Board to release it, and (b) it is released to a person who has a lawful right to the information.

Procedures for Addressing Conflicts of Interest

- If a member finds him/herself in a situation of conflict of interest or potential conflict of interest it must be disclosed to the Board or a Society executive.

- Any member may report potential conflicts of interest within the Society to the Board or to a Society executive.

- The Board, or a person designated by the Board, will discuss conflicts of interest with members who may find themselves in the situation. After discussion, the Board will review all cases of conflict of interest or potential conflict of interest with the Society member. It is the responsibility of the Board to resolve situations in which there is a conflict of interest. In the process of resolution, the Board may (1) ask the member to recuse him/herself from specific decisions or deliberations within the Society; (2) ask the member to remove him/herself from positions in which the conflict of interest exists until there is no longer a conflict; (3) ask the member to discontinue, reduce or modify his/her participation in Society committees or task forces in which a conflict exists.

All members of SACME, as well as individuals and entities who maintain a business relationship with the Society will be expected to abide by the stipulations in this policy.

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

CME*info*.com

News from the American Medical Association
WFME Global Standards for CPD Emerge in Recently Released Document

By Dennis K. Wentz, M.D.

My last column (October 2002) summarized American Medical Association (AMA) involvement on several continents to develop a global approach to continuing medical education (CME) and continuing professional development (CPD). Since then, the World Federation for Medical Education (WFME), based in Copenhagen, Denmark, has developed a document on "Global Standards for Continuing Professional Development (CPD) of Medical Doctors." The WFME Global Standards for Quality Improvement contain more than a few interesting and perhaps exciting directions for CME and CPD as we know it. Several elements speak to the question of the responsibility for the support of CME: a significant issue very much before all of us right now. [It is likely that this document will be a centerpiece at the annual WFME meeting in March 2003 —the CPD standards follow previously published WFME global standards for "basic" medical education and for "postgraduate" medical education, the terms used in Europe. See also their Web site: www.wfme.org.]

The AMA was privileged to be included in a team of reactors to a draft of the document last October in Copenhagen. In the document, the term CME was dropped in favor of the moniker "continuing professional development." Lively debate occurred at the meetings about whether the terms CME and CPD should both be used. Some argued that the term CME should be utilized for a while longer but the ultimate consensus of the group was to use "CPD" throughout the document. This reflects growing global sentiment and almost common practice in Europe.

The group employed the same principles used to develop the current published international standards for basic medical education and postgraduate medical education. These include the premises that only general aspects of CPD should be covered by the standards, that these standards should function as a lever for change and reform, that the standards should be formulated as a tool that individual doctors, the medical profession, authorities, organizations and institutions responsible for CPD can use, that the standards should acknowledge regional and national differences, and that ultimate compliance with these standards must be a matter for each community, region or country to decide. Quite appropriately, from my point of view, the document suggests that the standards should be further developed through broad international discussion and consensus.

The imperative falls on all of us to enter into this discussion at this crucial time in the development of worldwide CME and CPD.

So what are some of the key issues and items? The standards clearly make the profession, not the government or "authority bodies" responsible for CPD. Basic Standard 1.1 states: "The medical profession, in consultation with relevant authorities and employers, must define the mission and the intended outcomes of CPD and make them publicly known." It goes on to confirm this responsibility: "The statement of mission and intended outcomes of CPD must be defined by its principal stakeholders", and concludes: "CPD must serve the purpose of enhancing the professional and personal development of doctors."

The document goes on to specifically cite as standards many of the basics of adult education that most of us know well in the U.S. and Canadian system of CME, and I encourage you to review and discuss them. But we may have the most to learn from the WFME group consensus on the issue of support of CPD for medical doctors since the concerns about the support of CME in the U.S. and Canada have been growing at a frightening pace. Basic Standard 2.5 states: "CPD must be recognized as an integral part of medical practice reflected in budgets, resource allocations and time planning, and not be subordinate to service demands."

Another premise of CPD that most of us in SACME endorse occurs in Basic Standard 6.2: "In order to carry out CPD doctors must have protected time and opportunities for reflection on practice and for in-depth studies with access to adequate professional literature and opportunities for skills training." Is this WFME standard utopian? Is it just too good to be true? Is it implementable?

Finally, the WFME document declares that funding should come from the health

care system and from society for the benefit of all: "Funding of CPD activities must be part of the expenses of the health care system. Doctors' working conditions must enable them to choose and participate in CPD activities. Funding systems for CPD should ensure independence of doctors in their choices of CPD activities."

The SACME list-serve has recently been full of the media take, as reported by members, on the resources given to CME/CPD by commercial sources. We have seen increasingly harsh stories about this. Perhaps we should view this as a clear call to action, to promote a long-range direction different from the current focus on tuition revenue from individual participants and support by "industry" (defined broadly). While we know that other systems and workplaces do provide support for continuing education of their constituents — built-in support for maintaining knowledge is already the case in business, almost assured in academia, and, indeed, in most professions where there is an employer-employee relationship, it has never been viewed in that way in medicine. It is more complicated for our physicians as members of their profession. Medical doctors must be acutely aware of their contract with society and their sworn duty to individual patients.

I fear that unless we take some bold new steps, and all of us begin to make the case for the responsibility of society and the health care system for the support of CME and the needs of our doctors, the situation will continue to deteriorate. It is clear that an informed, up-to-date physician provides the best care, care that at the same time is also the most effective and in the long run, cost-efficient. The Institute of Medicine (IOM) has just released a report addressing the issues of improving health-care quality to make the system more efficient. The IOM report identifying 20 priority areas where government and private sources should focus research and resources in the name of quality was released in early January.

Quality care is what medicine must be all about. Is this an issue that we, the advocates and defenders of CME and CPD, should take on, an argument we should make to our elected officials and to the health care system? New and unexpected challenges will unfortunately come when the health care system (especially the government part of it) funds CME. But we can weather those if we keep our eye on the ball and emphasize another principle in the WFME document: "Doctors must have the ultimate responsibility for planning and implementing CPD for their individual needs."

We at the AMA are committed to involvement on a global level in CPD. If these standards gain acceptance in other parts of the world, can we afford not to have the debate that leads to another look at "our" system? To paraphrase Robert Frost, we may need to take the road less traveled by, and it may be lonesome and long. I believe we need to engage the debate and hammer out a worthy response to our critics but simultaneously propose a system that meets the expanded needs of patients, doctors, and society.

Summer Research Institute Planned at Dalhousie

By Nancy Davis, Ph.D.

The next Summer Research Institute will be hosted by Dalhousie University Office of Continuing Medical Education, Halifax, Nova Scotia, June 21-25, 2003.

The Institute is designed for both novice and experienced CME researchers. It will enable participants to select learning activities of most value to them at their level of skill and knowledge.

The curriculum includes framing the research questions, experimental design, critical appraisal of literature, designing questionnaires, using clinical data to assess performance, qualitative methods, conducting focus groups, integration of qualitative and quantitative data, writing proposals, writing articles for publication, and research in distance education. Participants will enjoy individual consultation with skilled researchers to further their proposals or studies. The goal is to assist attendees in completion of a project as a result of participating in the workshop.

Discount registration fees will be available for SACME and Alliance for Continuing Medical Education members.

Late June is also a wonderful time to be in Halifax. Come not only to work and learn, but to enjoy the ambience of a friendly city, the sea breezes, beaches, and of course, the sea food!

For further information, visit the SACME website, www.sacme.org for updates as planning proceeds; or contact any of the following planners:

- Joan Sargeant, 902-494-1995, joan.sargeant@dal.ca
- Michael Allen, 902-494-2173, michael.allen@dal.ca
- Nancy Davis, 913-906-6000, Ext 6510, ndavis@aafp.org

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UPCOMING EVENTS

February 28-March 1, 2003
Understanding ACCME Accreditation
Chicago, Illinois
Contact: Becky Flanigan (312) 464-2500

April 2-6, 2003
SACME Spring Meeting
Santa Fe, New Mexico
Contact: Shawna Tucker (505) 272-3942

June 21-25, 2003
"Summer Institute for CME Research 2003"
Halifax, Nova Scotia, Canada
Contact: Nancy Davis (913) 906-6000 ext. 6510; Joan Sargeant (902) 494-1995; Michael Allen (902) 494-2173

June 22-24, 2003
Global Alliance for Medical Education
8th Annual Meeting
New York, New York
Contact: Celine Chasen (713) 798-4024

July 25-26, 2003
CME: The Basics
Rosemont, Illinois
Web site: www.acme-assn.org

July 27-28, 2003
Understanding ACCME Accreditation
Chicago, Illinois
Contact: Becky Flanigan (312) 464-2500

September 8-11, 2003
14th Annual Conference of the National Task Force on CME Provider/Industry Collaboration
Chicago, Illinois
Contact: Regina Littleton (312) 464-4952

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