

## CONGRESS 2004: THE CME OLYMPICS

By Dave Davis, CME Congress 2004 Chair

Most long-time Society members feel that the Spring Meeting of the Society is the one not to miss – more coherent, all devoted to CME and CPD, more opportunity to meet just our CME friends and colleagues. *This* spring's meeting – CME Congress 2004 – offers all that and more. What's the "more"? What's the value added? Read on.

First, there are the *people*. As you probably know, the "Congress" is held every four to five years – Michael Allen, M.D. from Dalhousie University calls it the CME Olympics. As a major event in the life of CME, the Congresses bring together a broad range of people interested in the future of continuing medical education and continuing professional development, in regulatory policies and healthcare plans, in CQI and guideline implementation strategies, and others dedicated to closing the clinical care gap in practice. *This* Congress, more than any other, will attract an international audience from similar settings to yours. New friends and old – Canadians, Americans, Europeans, Aussies. You get the picture.

Second, there's the *program*. The Congress program takes place between Sunday, May 16 and Tuesday, May 18, 2004 at the Fairmont Royal York Hotel. The program is divided into five half-day blocks and five themes, with five, absolutely first-rate *keynote speakers*:

- *The health care environment* – Mark Smith, M.D., M.B.A. from the California Health Care Foundation (brilliant and eloquent health futurist, on what health care will look like in the next decade and its impact on CME)
- *The nature and form of 'information'* – Raj Mangrulkar, M.D. (wonderful teacher and role model on the role and delivery of information and its impact on CME)
- *Educational theory and practice* – Karen Mann, BN, M.Sc., Ph.D. (thoughtful educator, great speaker, on the role of education in CME)
- *Guideline and best practice implementation* – Jeremy Grimshaw, M.B., Ch.B., Ph.D. (internationally known scholar on guideline implementation)
- *Regulatory changes and their impact on re-certification, physician practice and CME* – Donald Melnick, M.D., FACP (knowledgeable thought-leader from the National Board of Medical Examiners)

The program also attempts to demonstrate some practical, take-home best practices in conference planning. Following each keynote plenary will be symposia, workshops, commentaries, paper presentations (there are over 80 of these by the way) plus posters and something called "*communities of learners*". These are self-directed small groups that meet throughout the Congress, learning from each other and applying principles and ideas



gathered from the larger sessions. Quite apart from the content of the meeting, conference organizers won't be disappointed by its unique format and flow.

The third and final value added is hard to capture. It's the "*other stuff*" that plays a large role in making any meeting – this one especially – successful. There's *Toronto itself* – big (4 million), clean, safe, accessible (regular flights from all major U.S. cities, super highways), great sports (Blue Jays, Raptors, Maple Leafs), great theater, plays, concerts, and (you can bet your bottom dollar on this one) great restaurants. And there's the *Canadian-American \$ thing*; you know all about that. And there's the great, classy old-but-refurbished hotel, the *Fairmont Royal York*. And finally, with a planning committee led by R. Van Harrison, Ph.D., fund-raising led by Paul Lambiase, and the University of Toronto CE Office lending all its logistical support – this meeting will be truly memorable.

So there you are, the scoop on CME Congress 2004 – Toronto's CME Olympics. Come visit us virtually at [www.cmecongress.org](http://www.cmecongress.org) for all the details. Then come see us in person, this spring, in Toronto. See you there.

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# FROM THE PRESIDENT

## COME GROW WITH US

By Nancy Davis, Ph.D.

It's a new year and I've passed the half-way point of my presidency so it seems a good time to reflect on SACME successes.

### Membership

SACME passed the 200 member mark in 2003 with almost every medical school represented. Membership has enjoyed consistent growth and this year has been no exception with an average of two to three new members joining each month. We welcomed seven new members the month following the Fall meeting.

### Research in CME

The Summer Research Institute was a great success once again with many participants working on CME research projects to fulfill graduate degrees. Those of us who serve as faculty gain as much as our learners. The research workshop held at the Fall Meeting on developing effective questionnaires met the needs of novices as well as experienced researchers. RICME has become more interactive and provides an opportunity to learn research skills and methods as well as results of specific studies. A new structure will ensure that the winner of the Decker Award, given for best research article published in the *Journal of Continuing Education in the Health Professions*, will present his/her work at the Spring Meeting and that the Fox Award for best abstract will continue to be presented at the Spring meeting each year. The Research Endowment Council conducted a very productive strategic planning session at the Fall meeting that resulted in broader strategic planning for the organization in January and the development of a research agenda for SACME.

### Educational Programs

SACME's educational programs have a reputation for being high quality and relevant to academic CME professionals. Last Fall's session matching Dr. Arnold Relman and Richard Samp, Chief Counsel of the Washington Legal Foundation, provided opportunity for provocative and timely discussion. Up-to-date information regarding competency-based relicensure of physicians, maintenance of certification, and LCME criteria for CME rounded out a very well received program. It's not accident that membership applications go up following our successful programs twice a year!

### Communications with Members

SACME's website, including a "Roadmap for Research", provides valuable resources for members whether they need assistance with research, regulation or best practices. The website is professionally developed and maintained.

The SACME member listserv is active with members frequently sharing information. If you haven't subscribed to the listserv, I recommend you do. Valuable information and updates are exchanged there. *Intercom*, as you can see here, is a high quality quarterly newsletter, available in print and electronic format, providing news, photos and reminders.



### Advocacy

SACME members are represented by regional representatives using the same region boundaries as recognized by the GEA. A recent bylaws change allows for a Canadian regional representative who will be appointed at the Spring Meeting. SACME executives have regular communications with relevant external organizations including the Association of American Medical Colleges, the American Medical Association, the Accreditation Council for Continuing Medical Education, and Council of Medical Specialty Societies. Monthly phone calls between SACME leadership and executives in each of these organization assures member needs are represented. SACME was awarded observer status by the AMA House of Delegates this year.

### Leadership

I have the privilege of leading a hard-working volunteer board. They are consistently present for conference calls, prepared and ready to work. Our four-year leadership advancement track including Vice President, President-elect, President, and

### INTERCOM

*Intercom* is published three times a year by the Society for Academic Continuing Medical Education, Executive Secretariat Office, 3416 Primm Lane, Birmingham, AL 35216; Telephone: (205) 978-7990; Fax: (205) 823-2760.

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

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Immediate Past President provides continuity and a team-approach to leadership.

Given the dynamic activities of SACME, it's not hard to understand why so many academic CME professionals are drawn to this member-friendly, supportive organization. This year, SACME members have been concerned about the prevalence of pharmaceutical support of CME, the lack of financial support of their medical schools, and their image as service department rather than academic department. We are working toward better synergy between SACME and AAMC. We have many common concerns and must work together to address them. A recent letter to Michael Whitcomb,

Senior Vice President, AAMC Medical Education, outlined many of the successes listed here and offered SACME as AAMC's liaison to academic CME professionals.

I hope our new members will get involved. A professional organization is only as valuable as you make it by participating. There are lots of opportunities to serve. We're small enough to be friendly and large enough to make things happen. I look forward to seeing you at the CME Congress in May. It promises to be a wonderful program and with you there, it will be a great opportunity to network and grow professionally.

See you in Toronto.

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## HIGHLIGHTS FROM THE FALL MEETING

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The SACME 2003 Fall Meeting was held in conjunction with the 114th Annual Meeting of the Association of American Medical Colleges, November 7-12, 2003, in Washington D.C. The meeting was extremely well attended and many thought the program was "the best ever." Arnold Relman, M.D. (top left) and Richard Samp (top right) spoke to an overflowing crowd on this year's hot topic, commercial support and continuing medical education. The photo on the bottom right shows Jim Thompson, M.D. (right), Federation of State Medical Boards, and Steve Miller, M.D. (left), American Board of Medical Specialties, who spoke about competency based licensure and maintenance of certification, respectively. Past presidents gathered for breakfast and posed for a photograph (bottom left). They are, from left: Paul Lambiase, Jack Kues, Ph.D., Dave Davis, M.D., R. Van Harrison, Ph.D., Nancy Davis, Ph.D., Robert Cullen, Ph.D., Dale Dauphinee, M.D., and Dennis Wentz, M.D. And, finally, the beloved Dennis Wentz, M.D. (top center) was toasted and honored on the occasion of his then impending retirement from the American Medical Association.



# PHYSICIANS INTERNET USE: SEEKING INFORMATION

By Linda Casebeer, Ph.D., Nancy Bennett,  
Ph.D., and Robert Kristofco, M.S.W.

Use of the Internet has become common among physicians, raising questions about its role in learning and in patient care. An American Medical Association study reported that 10% of physicians surveyed in 1997 were Internet users, and 78% in 2001. Physicians reported most frequently using the Internet for e-mail, medical information sources, travel information, product information, and professional association communications.<sup>1</sup>

The largest obstacles to Internet use cited by medical professionals were lack of time for searching, dissatisfaction with speed, and lack of ease of use in searching for information.<sup>2</sup> Although use in courses that provide continuing medical education (CME) credit is low compared to live CME courses, the annual report of the Accreditation Council for Continuing Medical Education indicates significant increases in the use of on-line options.<sup>3</sup>

In connecting concepts about motivation, learning, and a need for information, we hypothesized that physician Internet information seeking behaviors would be influenced by previous information-seeking experiences, and by demographic characteristics such as practice location where the Internet might offer previously unavailable access to information. We predicted that more information about physician information-seeking behaviors would help us to use related theories and provide more theoretical activities constructs for the development of on-line activities.

## Method

A survey of twenty-one multiple choice questions was conducted by facsimile transmission (Fax). Fax surveying has been demonstrated to be effective in eliciting survey responses from practicing physicians.<sup>4</sup> The use of Fax rather than an Internet survey was chosen to avoid the bias of surveying only those physicians who already are active Internet users.

The population of interest was defined as U.S. physicians of all specialties in active, community practice according to the most current American Medical Association physician listing. There were 324,000 physicians identified. A power calculation determined that a sample size of 2,200 was needed to generalize to the total population. Cochran's sampling technique was used, with a margin of error of 5%, and 95% confidence.<sup>5</sup>

**Editor's Note:** The paper in the *Journal of Continuing Education in the Health Professions* which this article summarizes won the 2002 Decker Award given for the best research article published in the journal in a given year.

**Table 1. Physician Experience in Internet Use**

E-mail	90%
Personal use	86%
Literature searching	65%
Searching for medical information	53%
Accessing on-line journals	45%
Professional association updates	33%
CME	31%
Searching for specific patient information	29%
Consultation with colleagues	17%
Filing insurance claims	13%
Participating in clinical trials	7%
Writing prescriptions/patient orders	2%

## Results

Two thousand two hundred usable surveys were returned. Responses included 79% male and 21% female physicians. Thirty-two percent of physicians responding represented primary care specialties and 68% were from all other major specialties. Practice locations included 37% urban, 40% suburban, and 23% rural locations. The majority of respondents (58%) practiced in group practices. Eighteen percent of respondents had graduated from medical school within the past 10 years, 36% between 10 and 20 years, and 46% more than 20 years prior to the time of the survey. A total of 34% of the respondents reported using the Internet more than five years.

Eighty percent of respondents reported currently using the Internet in various ways to find medical information, including literature searching, accessing on-line journals, general searching for medical information, and searching for specific patient information (Table 1). Physicians were asked which variables were the most important in seeking medical information on the Internet. Forty-one percent identified credibility of the source as most important, 35%, quick and 24-hour access to information, and 24%, ease of searching.

A particular patient problem was ranked as the strongest motivation to search for Internet information (Table 2). Physicians were asked if they found the information they wanted. Sixty-two percent reported they usually found it, and 28% reported they occasionally found the information. When asked if their search skills were sufficient, 61% said their search skills were sufficient, 26% partially sufficient, and 13% not sufficient. Physicians were also asked if they used the Internet information they found. Seventy percent reported usually or always using the information, and 25% reported occasionally using the information. When asked about the largest barrier to the use of the Internet, 28% reported not being able to find what they were looking for (Table 3).

Male physicians had more experience and confidence using the Internet than female physicians. There were no significant differences between male and female physicians in finding and

using information. More male physicians than female expected to use the Internet in the future at the request of patients ( $p=.02$ ). Female physicians found local traditional CME to be more helpful than their male counterparts ( $p = .0042$ ).

## Discussion

The results of the study raise four questions reflecting ways the Internet supports physician professional development. First, *who is using the Internet?* Almost all physicians have access to the Internet and know how to use it. However, there are differences in use by gender, practice location, and specialty that suggest unique approaches by different groups of physicians, and special uses important for developers of on-line programs.

Second, *what are the ways physicians use the Internet?* Traditional CME courses, journals, and local CME meetings remain important to physicians for their learning. The most frequent usage is for personal business and e-mail. However, that response does not convey the more complex pattern of information searches for patient problems<sup>9</sup> demonstrated in this study.

A large majority of physicians was motivated to search on the Internet for a specific management problem, and information was found and used by the majority of searchers. This form of information gathering is developing its identity in the portfolio of options for physicians and fits with the importance of the utility of information in information seeking, as well as the emphasis on a specific patient problem as a motivator for physicians' self-directed learning.<sup>6-8</sup> Those searches that do not result in helpful information for management strategies may reflect the uneven quality of material found among the huge number of available options, as well as the structure of medical knowledge, the way it is indexed, and the way it is retrieved, a problem previously cited as a barrier to adoption of new information.

Third, *when are physicians using the Internet and what are the barriers to use?* Physicians report using the Internet multiple times each month, primarily for personal use and e-mail, but also for searching the literature and accessing journals. Barriers for such a large resource are predictable: too much information to scan and too little specific information to respond to a defined question.

**Table 2. Physician Motivation for Internet Searching for Medical Information**

(1= highest motivation; 6= lowest motivation)

	Mean	SD
Particular patient problem	1.75	1.16
Scanning new information in a disease area	2.32	1.1
Latest research on a specific topic	2.60	1.28
New product information	3.38	1.14
Specific drug dosage	3.94	1.31

**Table 3. Physician Perceptions of Largest Barrier to Internet Use**

Too much information to scan	30%
Not able to find information	28%
Inadequate searching skills	23%
Slowness of loading information	16%
Need for additional software plug-ins	3%

And fourth, *what does the evidence suggest to providers of CME about their new role in developing this learning resource for physicians?* The value placed on ready access to journals, and ease in searching literature matches a long-standing commitment to local traditional CME programs. Compared to journals and local CME programs, hospital rounds and home study options appeal to a subset of learners.

Keeping up-to-date via the Internet provided the same value as local hospital rounds. Traditionally, many smaller hospitals invite outside experts to cover a range of topics. Some topics lack relevance for any given individual in the group. The focus may not be appropriate to the specific setting, such as tertiary care issues in a community hospital. Rather than a general dissemination of information, the Internet demands a specific goal for each search. Shifting from a general scan to a defined question with a specific outcome demands some changes in learning systems. Further, traditional schooling places high value on direct interaction with teachers and traditional resources such as textbooks. That model continues with hospital lectures. If the role of the expert is reconfigured in the Internet, physicians must use new criteria to assess credibility.

Not surprisingly, in the eyes of users CME on-line must be immediate, relevant, credible and easy to use. The utility must be focused and well indexed. The ability to effectively gather a more in-depth understanding depends on hyperlink levels, rather than linear access. Faculty credentials, institutional identity, and appropriate CME credit are criteria used to evaluate the quality of a program.

The results of this study suggest that continuing educators redefine their role in terms of how information seeking links to traditional CME planning. Physicians construct the kind of knowledge they need by using their own experience and the information they find. Rather than a single piece of data as a defining answer, the study suggests that physicians build a picture by using pieces of data from several sources. At this point, help in locating materials more than the development of those materials may be an important function for CME. For example, rather than a focus on new content, links between professional association updates, breaking news, and sources for specific patient management strategies might be helpful. Teaching search skills or facilitating searches at a more sophisticated level would provide ready access to content developed within the Internet system.

In summary, the Internet provides an extensive and ever-growing resource center available to physicians as part of a self-directed curriculum. Its range of options and varying quality of information provide both a challenge and a barrier to finding relevant answers to questions. Support for physicians using the Internet from those in CME requires some new roles for CME providers. In designing on-line CME programs, patient problems presented as cases could make important information more accessible than transforming traditional lectures into on-line CME. Indexing in order to make relevant clinical content accessible to physicians who may not be sophisticated in information-seeking strategies is also important. Supporting retrieval of information, pointing to and consolidating resources, and looking for definitions of credibility may take precedence over traditional kinds of programming.

### Acknowledgments:

This summary is based on a more extensive report in the *Journal of Continuing Education in the Health Professions*:

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### Lessons Learned from the Study

Increasingly, physicians are turning to the Internet for professional development and intend to do so more often in the future.

The most common reason physicians seek information on the Internet is to search for information on a specific patient problem.

In pursuing professional development on the Internet, physicians expect access to information to be immediate and easy to use, and they expect content to be relevant and credible.

Based on the physician's need for information on a specific patient problem, adopting case-based learning as a component of the design of on-line CME courses will enhance the utility of on-line courses.

The roles of the continuing educator must be reshaped to include helping physicians seek and construct the kind of knowledge they need to improve patient care.

## SACME LISTSERV CHANGES NAME

The SACME Listserv has changed its name as of January 1, 2004. The old listserv name (SMCDCME@Lists.Wayne.edu) has been changed to (SACME@Lists.Wayne.edu) to reflect the change in the name of the Society that took place several years ago. Everyone who was subscribed to the old listserv has been given a subscription to the new listserv and should have already received a number of postings to the new listserv since January.

The only other noticeable change is to the listserv archives that can be found in the Members Only section of the SACME web page. The archives from the SMCDCME Listserv (April 1997 through December 2003) are still available on the web page but a second archive has been started for the SACME Listserv as of January 2004.

If you have any problems with receiving listserv postings or accessing the archives please contact Jim Ranieri at (205) 978-7990 or [sacme@primemanagement.net](mailto:sacme@primemanagement.net). SACME is grateful to Dave Pieper, Ph.D. for his services as listserv manager and for hosting the listserv through Wayne State University.



# RETRACING OUR ROOTS - A SERIES OF INTERVIEWS

## WITH SACME FOUNDERS AND LEADERS

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Dr. John Parboosingh was SACME President from 1999 to 2000 and has been actively involved in the administrative and editorial boards of the *Journal of Continuing Education in the Health Professions*. He was interviewed on October 2, 2003 by Barbara Barnes.

*BB: How did you get involved in CME?*

JP: When I practiced in Scotland, I developed clinical outreach programs to improve the care of women with high-risk pregnancies and recognized that community physicians also needed educational support. At the time, this was a very unique model and when I relocated to Calgary, the dean asked me to set up something similar. He was really quite a visionary in recognizing the importance of CME in supporting a medical school's accountability to regional patient populations.

*BB: When did you get involved in the Society and how did it support your career?*

JP: I became involved in the early '80's. Jocelyn Lockyer and I were doing some very interesting things in Calgary but I felt professionally isolated – a position that Jim Leist described as a “marginal dweller”. My earliest memories of the Society relate to the warm welcome I received from a number of individuals including Dale Dauphinee, Phil Manning, Paul Mazmanian, and George Smith. We were a group of people looking for a professional identity and had a common need: getting the attention of our deans. We supported each other personally and professionally and were able to work together to implement research projects and develop the Journal. I have always felt that the Society is very egalitarian, not differentiating between M.D.s and Ph.D.s. This creates a much more collegial atmosphere than I have often found in the medical school environment.

*BB: Was the Society different in those days?*

JP: Yes, it differed in several ways. First of all, the organizational structure was much less formal. The president, or, more accurately, the president's secretary, was responsible for administrative support. The Society always met twice a year, but there was little contact between meetings. Also in those days, most members were deans or directors (reflecting the prior name “Society of Medical College Directors of CME”). I don't think we had as much participation from Canada.



*John Parboosingh, M.D.*

*BB: What hasn't changed?*

I can remember how difficult it was to obtain funding for the change study, our first multi-institutional research project. It took Bob Fox and Harold Paul three years to secure the support. Unfortunately, we still struggle to fund research.

*BB: In your view, what have been some of the major accomplishments of the Society?*

JP: RICME began as a small circle of people, in large part through the efforts of Phil Manning and Dave Davis. We have considerably broadened the scope of individuals participating in research through RICME, the endowment, and the summer institute. We also have to recognize the role of the Society in the growth of the journal as well as the production of the two books. Few academic societies can point to high quality products such as these.

*BB: How did you approach your presidency?*

My term of office came at a time of some internal division in our organization. I attempted to listen to our members and help them incorporate new ideas into a constructive vision for the Society.

*BB: How has SACME influenced your career?*

The Society has contributed significantly to my professional development. There was initially some resistance in Canada to the concept of maintenance of competence and self-directed learning and reflection. Our organization gave me an opportunity to obtain feedback on my project and I benefited considerably from presentations at RICME as well as personal interactions with colleagues. As the MOCOMP project (Maintenance of Competence Project of the Royal College

of Physicians and Surgeons of Canada) developed, the Society helped to publicize the project, promoting its recognition and adoption.

*BB: What is your vision for the Society?*

We need to continue to build bridges with other organizations in order to translate research into practice and to further explore the field of knowledge management. We have to help CME

professionals move beyond their day-to-day issues in order to pursue research and better understand how they can use research and theory to improve physician competence. In order to achieve this, we must create a model for developing learning mentors. There is a lot of work to be done and many more things to understand about how physicians learn and change.

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## DEADLINE FOR THE PHIL R. MANNING AWARD HAS BEEN EXTENDED

By Jan Z. Temple, Ph.D., Endowment Council Chair

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CME researchers have until September 2004 to submit final proposals for the prestigious Phil R. Manning Award. Letters of Intent are encouraged to be submitted to the Endowment Council with awards scheduled to be announced at the Fall Meeting. The Manning Award was created in October 1998 as a mechanism to stimulate and advance research in CME while recognizing the many contributions to CME research of Phil R. Manning, M.D., recently retired from the University of Southern California, Los Angeles. Dr. Manning is considered the founding father of the Society. The Endowment Council views research as the vehicle for making CME more effective in improving physician competency. Up to \$50,000 for a two-year period are available for projects relevant to the profession that transition research into practice using models with practical application in CME environments. Evidence-based CME involves applying the best available information on how physicians learn and change to the planning, delivery, and evaluation of CME. This approach is the cornerstone of the Endowment Council's recommendations in research funding. Detailed information on the application process can be found on the SACME website ([www.sacme.org](http://www.sacme.org)).

The first Manning Award was given in 2000 to Yvonne Marie Coyle, M.D. from the University of Texas Southwestern Medical Center at Dallas for her project titled "Role of Continuing Medical Education in Assessing Health Care Performance." This two-year project assessed the effect that CME has on performance measures impacting the quality of care and health outcomes. Investigators evaluated a non-traditional, individualized self-directed program by targeting a group of physicians to assess its potential for promoting positive clinical performance change and improved patient health status. The evaluation design for the study used both qualitative and quantitative outcome assessments similar to a learning contract

with specific learning objectives for each study participant. Findings indicate that if CME providers want to meet the challenge of enhanced performance measurement in health care, they need to work with health plans to develop report cards that have links to CME. Research has shown that feedback on clinical performance is more effective in changing behavior if it is linked to education. Therefore, it is critical to connect CME content to the provider clinical performance and patient health status data that are tracked by health plan report cards.

A second Manning Award was granted in December 2002 to Gabrielle Kane, M.B., M.Ed., FRCPC from the University of Toronto for a project titled "Examining the Impact of Change on Professional Practice." This qualitative study examines the impact of technical innovations on learning and developing new knowledge and resulting changes in the practice of radiation oncology. High precision radiation treatment (HPRT) is a new and developing technological capability that will be studied by the Radiation Medicine Program (RMP) of a large academic multi-professional practice. New knowledge and skill will be needed for the initial introduction; however, more new knowledge will be generated and developed by the tumor group members of the RMP. Changing practices and patterns of care affect not only the physician, but also the other health professionals on the team and can shift staff roles and responsibilities. This study examines the impact that change has on these elements from the perspective of the RMP practitioners. It will include their views on the generation of new HPRT knowledge and how application of this knowledge changes radiation therapy and the organization of RMP. It will also identify features of the practice that facilitate learning and integration of change. A progress report on this study was given at the 2003 SACME Fall Meeting.



# SUPPORTING SACME MEMBERS AND THEIR RESEARCH

By Joan Sargeant, B.N., M.Ed.

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Over the past year, a number of SACME members have expressed interest in enhancing their research skills, increasing their research potential, and being able to participate in research studies. In response, the Board, the Research Committee and the Research Endowment Council have undertaken a number of initiatives. This article provides an update on these activities and a view toward things to come.

Participants in the SACME Summer Research Institute, June 2003, provided thoughtful suggestions for the kind of support that would help them continue their research after they returned home. These included suggestions for both continuing development of their research skills and for support to enable them to undertake research studies. Many of these related to providing mentoring in some way to help them translate their learning into research practice (*Intercom*, October, 2003). Through the SACME Executive Leadership Retreat, also held in June, 2003, and subsequent discussions with SACME research leaders, several recommendations were made to promote research, including: (1) revamping the RICME (Research in CME) format at the Spring and Fall meetings to involve more interaction between senior and junior researchers; (2) encouraging more presentations and discussions by senior researchers; (3) including presentation of the *Journal of Continuing Education in the Health Professions* Decker Award and Research Endowment Manning Award papers during RICME sessions; and (4) developing a formal mentorship program.

In response to these suggestions, several changes were implemented, and well received, during the RICME session at the Fall Meeting, 2003. One was the invited review by three senior researchers of a research presentation (with the prior permission of the presenter, of course!). This engaged the audience in interaction, and we thank Gabrielle Kane, M.B., M.Ed., FRCPC, the presenter and Manning Award recipient, and the reviewers for their open discussion. Another was the presentation and lively audience discussion of the 2002 Decker Award paper by Linda Casebeer, Ph.D., Nancy Bennett, Ph.D., and Robert Kristofco, M.S.W. To wrap up the RICME session, a large group brainstorming session was held to identify strategies for supporting research and nurturing researchers. Many great ideas came forward:

1. Promote collaboration, mentorship, and sharing among members. One suggestion is to involve members with varying degrees of expertise in multi-site studies, so those with less experience can learn from those with more.
2. Continue promotion and development of the Summer Research Institute. The social interaction and learning that take place on site are important to improving skills and knowledge.
3. Provide assistance in writing grant applications.
4. Encourage and support members who are trying to write for publication.
5. Encourage and support members throughout the research process, for example, helping them to allocate the time to do research, and helping them to find mentors within their own institution.
6. Develop a mentorship program in which those with experience can mentor and support others as they're beginning and conducting their research.
7. Create partnerships among individual members.
8. Promote use of the RDRB as a tool for determining what is known about a specific topic and as a foundation for informing and developing research grants.
9. Provide a glossary of research terms on the website.
10. Define what we mean by research, evaluation, and scholarship (for example, research, innovation, and dissemination), as there are many ways to make contributions.
11. Assist with standardization of common evaluation questions and tools.
12. Post these tools on the website. (This would be a tremendous help for those just beginning or who are working alone.)

These are very helpful suggestions and the Research Committee, Research Endowment Council, and the Board are now attempting to prioritize them, to determine what is realistic given the volunteer nature of our membership, and to develop an implementation plan. This process is very much aided by a parallel undertaking, the Research Endowment strategic planning process, led by Jan Temple, Ph.D. More will be available about this and the research support initiatives in a later issue of *Intercom*.

# NEWS FROM THE AMERICAN MEDICAL ASSOCIATION

By Charles E. Willis, M.B.A.

For the first time, you will read a “News from the AMA” column not authored by Dennis Wentz, M.D. Following Dr. Wentz’s retirement Greg Paulos, formerly associate director for CPPD, left to lead educational activities at the American Society of Gastroenterological Endoscopy. Since then I have carried both the privilege and responsibility of representing the AMA PRA credit system. Until a new division director comes on board, I will also rely on the work of Rebecca DeVivo who directs our accreditation and certification activities, and exercises professional oversight of the annual conference of the National Task Force of CME Provider/ Industry Collaboration. I hope many of you had a chance to meet her at the Alliance meeting – like the rest of us in CPPD, her door is always open to lend whatever assistance she can to your endeavors.

Since I believe that we ride the shoulders of those who have come before us, I would like to publicly thank both Dr. Wentz and Greg for mentoring Rebecca and me during the time we were able to work together. We learned a great deal about leadership, strategic thinking and the power of developing relationships. In particular, with Dr. Wentz I saw a nuanced understanding of the credit system, its relationship to physician professional development and a tremendous patience with others. He always took the long view: from the evolution of the credit system and the imperative of international CME, to rethinking how we fund CPD. We will miss you for “la gentileza de los que saben [the gentleness of those who know].”

SACME has served as a great resource for CPPD and our work on behalf of the AMA PRA, and I am proud to count myself as a newly minted member. Despite the latest technology and the sea of paper we can never quite swim out of, it seems to me all essential communication remains rooted in the oral tradition. Thus it’s the conversations with many SACME members that have shaped my thinking and proved so helpful down the road. From among these interactions, I would like to acknowledge Nancy Davis, Ph.D., for her fierce defense of documenting change in CME and R. Van Harrison, Ph.D., for his surprisingly formalist view of CME credit systems. Because of SACME, “the community of professional educators” has entered my lexicon.



Shifting gears to content matters, I know Dr. Wentz in multiple venues has laid out what our principal initiatives and activities are. I would like to elaborate on how we might address translating components of traditional CME to physician-directed Internet CME and performance measurement/ improvement activities, both to be recognized for AMA PRA category 1 credit later this year.

First, everyone agrees that CME, and credit awarded for participating in a given activity, links optimally to some form of change: cognitive, performance and eventually patient outcomes. However, should the AMA PRA abandon the exposure model of traditional CME for these other learning modalities?

In my view, no, although the steering committees for both pilots will have to suss out final recommendations on that point. Physicians can still be expected to absorb information from reading and through lectures, as part of that continuum of activities by which they ultimately change their practice.

A related issue confronts us with physician-driven Internet CME: should the value of the educational experience be linked just to the search for specific clinical/formulary information, or should we also expect subsequent reflection and documented change in practice? Mark Ebell, M.D., one of the principals in American Academy of Family Physician’s pilot project with InfoRetriever (using handhelds at the point of care), takes the contrarian’s position that the full activity (and the associated credit) can be limited to the interval of patient interaction. He cogently argues that a busy clinician spends very little time with primary sources and that his group has already sifted through the mass of literature in order to develop POEMs (**P**atient **O**riented **E**vidence that **M**atters). So the issue is far from settled.

Second, we need to look at what Steve Minnick, M.D., chair of the steering committee for the Performance Measurement pilot project, calls “operating definitions.” The terms we use bear special freight, especially at this juncture when we seek

to amplify the credit system. In light of this concern, I have focused on performance and not on an assertion of competency. The latter term shades into different usage depending on context: the ACGME competencies suggest the habits of mind necessary to be an effective physician, whereas the ABMS competencies fold in toward a performance metric (“periodic self-assessment” and “performance in practice”).

An assessment of competence will also vary according to the

observer; a patient might calibrate competence differently from a licensure board, a fellow physician or an insurer. We stand on firmer ground if the focus remains on performance. In that manner, AMA PRA guidance on performance measurement/improvement activities will supply physicians with an educational tool not tied to any specific demands that might be placed on them – or their CME/CPD credit system. In closing, thanks in advance for your comments and input – I look forward to seeing all of you at the Congress in May.

## MEDBIQUITOUS: A CONCEPT WHOSE TIME HAS COME

By Nancy Davis, Ph.D.

The MedBiquitous Consortium is an international group of professional medical associations and related organizations that are creating an XML framework for continuing professional education. Its impressive list of members includes several medical specialty societies, Johns Hopkins University (where it was founded), the Centers for Disease Control and the Association of Academic Health Centers.

MedBiq uses a set of standards for on-line learning called SCORM (Shareable Content Object Reference Model). This is becoming the industry standard for on-line education. SCORM consists of standards for learning objective metadata and content packaging and a run-time environment for learning objectives. The fundamental instructional unit is called a SCO (shareable content object).

In the past year, MedBiq has been focusing on development of a standard curriculum defined as:

- Content (knowledge to be transmitted)
- Competencies or objectives (results)
- Process of training (description of educational activities)
- Evaluation/Assessment

Standards include mapping the learning model to the curriculum; tracking learner progress; guide for educators to place content in the curriculum; and assistance for curriculum creators.

The curriculum model looks like this:

### Curriculum

Title  
Intended audience  
Description  
Goal  
**Unit**  
Title  
Description  
Unit Objective

### Topic

Title  
Description  
Activity  
Competency  
Assessment  
Performance measure

### Assessment

### Subtopic

Title  
Description  
Activity  
Competency  
Assessment  
Performance measure  
Assessment

This could have important implications for Maintenance of Certification. Specialty societies might develop curricula and share documentation of physician participation with appropriate certifying boards.

Specialty societies or other providers might develop “chunks” of content to be shared with one another. Useful “chunking” would be into individual “lessons” rather than larger “courses” to be effective for sharing.

Assessment could be tied to each activity and aggregated to provide data for needs assessment for future education, assessment of the specialty as a whole, or other applications. Successful completion of content could be electronically reported to certifying boards, licensing boards, hospital credentials units, or specialty societies.

For more information go to the MedBiquitous website: <http://www.medbiq.org> or contact Valerie Smothers, [vsmothers@medbiq.org](mailto:vsmothers@medbiq.org).



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## UPCOMING EVENTS

April 18-19, 2004

Understanding ACCME Accreditation  
Chicago, Illinois  
Contact: ACCME (312) 755-7401

May 15-18, 2004

CME Congress 2004  
Toronto, Ontario, Canada  
Contact: Conference Secretariat (416) 978-2719

July 30-31, 2004

CME: The Basics  
Rosemont, Illinois  
Website: [www.acme-assn.org](http://www.acme-assn.org)

August 1-2, 2004

Understanding ACCME Accreditation  
Chicago, Illinois  
Contact: ACCME (312) 755-7401

September 27-30, 2004

15<sup>th</sup> Annual Conference of the National Task Force on  
CME Provider/Industry Collaboration  
Baltimore, Maryland  
Contact: Regina Littleton (312) 464-4637

November 5-7, 2004

SACME Fall Meeting  
Association of American Medical Colleges  
Boston, Massachusetts  
Contact: Jim Ranieri (205) 978-7990

December 10-11, 2004

Understanding ACCME Accreditation  
Chicago, Illinois  
Contact: ACCME (312) 755-7401

January 26-29, 2005

2005 Alliance for CME Annual Conference  
San Francisco, California  
Website: <http://www.acme-assn.org>

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*.



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