The Society for Academic Continuing Medical Education

INTERCOM

THE SOCIETY FOR ACADEMIC CONTINUING MEDICAL EDUCATION

Society Takes Active Role in Responding to Articles in the Public Press

By Jack Kues, Ph.D.

In the April 19 on-line edition of *The Wall Street Journal*, Scott Hensley authored a story entitled, "Doctors' Continuing Education Needs Prescription for Change." Most of the article was devoted to a description of a study conducted by Dr. Manesh Patel in which adherence to guidelines for the treatment of heart attack was compared between states that required continuing medical education and those that did not. Dr. Patel concluded that CME was ineffective because there were no significant differences in the treatment of heart attack victims in the required and non-required CME states. The study, reported to be published in an upcoming issue of the *Journal of the American College of Cardiology*, raised the issue of pharmaceutical company support for CME activities. Mr. Hensley devoted the second half of his article to what he describes as "…the growing influence of the pharmaceuticals industry on [CME]." He used quotes from both R. Van Harrison, Ph.D. and Murray Kopelow, M.D. to support his assertion that industry funding for CME activities is problematic. Unfortunately, this is exactly the kind of reporting that results in a great deal of confusion, and even anger, among the general public and critics of CME.

There was a great deal of discussion about this article on the SACME listserv. As a result, I volunteered to write a Letter to the Editor of *The Wall Street Journal*. The letter criticized both the serious flaws in the study and the obscure links between the conclusions of the study and pharmaceutical support for CME. The letter was endorsed by the Boards of both SACME and the Alliance for Continuing Medical Education and was also sent to the editor of the *Journal of the American College of Cardiology*.

Over the last several years there have been an increasing number of similar articles in the popular press, many of which have found their way into the hands of faculty, course directors, department chairs, administrators, and deans. Many of us have been caught off guard and called upon to answer allegations without having read the precipitating article or having had time to prepare an organized response. As CME providers, we are acutely aware of some of the issues and challenges we are facing. The new draft Standards for Commercial Support have begun to address some of these issues and each of us is developing mechanisms to ensure high quality education that is effective in improving health care delivery. These articles seldom offer suggestions for improvement or highlight the scientific studies that demonstrate the positive impact of CME on knowledge and practice.

It is critical that we become more alert to what appears in the public press and that we respond professionally. We should not ignore legitimate criticisms of CME. They are the foundation of our planned improvements and changes. Conversely, if, as in the recent *Wall Street Journal* article, the criticisms are based on faulty science and conjecture, we need to address those issues directly. Our replies should be grounded in facts, statistics, and scientific evidence. It is incumbent on us to be knowledgeable in these areas. The SACME listserv and web page, the *Journal of Continuing Education in the Health Professions*, the Research and Development Resource Base (RDRB), and national meetings, are all excellent resources. In addition, it is our professional responsibility to generate quality research that gives us more insight into the issues and test our proposed changes. The recent CME Congress 2004 highlighted the need for translational studies and models to affect change. We are all being challenged to know more about literature in our field and to participate more actively in our profession. And we must all rise to this challenge.

In This Issue

From the President

By Craig M. Campbell, M.D.

It is my honor to serve as the 28th President of the Society for Academic Continuing Medical Education. Although the context and challenges we face in continuing professional development are different in Canada and the United States it is our passion for contributing to the academic component of our discipline that is one of the driving forces that energizes and unites us as a society. It is this aspect of our Society that I wanted to highlight in this issue of *Intercom*.

Although in other sectors the word "academic" is typically equated solely with research, the term academic for the Society for Academic Continuing Medical Education is clearly a broader term encompassing multiple aspects of scholarship: the scholarship of innovation, education, translation (of research evidence into practice) and the scholarship of generating new knowledge (both theoretical and practical) that facilitates our ability to enhance physician performance and improve patient care outcomes.

It has only been two weeks since attending Congress 2004 in Toronto. This was a wonderful conference that provided a broad array of plenary sessions, symposia, workshops, and research/demonstration projects from around the world centered on how we can enhance the translation of knowledge into practice. The membership of our Society contributed immensely to the success of this prestigious event in a number of ways. The entire Congress planning committee, consisting of Dave Davis, M.D., R. Van Harrison, Ph.D., and Paul Lambiase are active members of our Society. In addition, more than half of the Scientific Program Committee members, who sifted through and reviewed a multitude of abstracts and symposia submissions, are members. During the Congress, members contributed significantly in every aspect of the conference from providing commentary on plenary sessions to presenting their ideas, innovations, and research work within each of the dimensions of knowledge transfer. It is little wonder that we have established ourselves as THE academic society for continuing professional development. It is what differentiates us from all other CME/CPD organizations and it is at the heart of who we are: a group of continuing education professionals committed to scholarship in all of its manifestations.

However, there is a growing urgency and commitment within our membership to enhance our leadership role in academic CME. The most recent biennial survey (see page 3) has revealed a decline in the number of CME offices who responded they are engaged in research. There is growing concern about our continuing ability to support and fund research projects at our traditional level, let alone increasing our capacity to support research, based on our current fiscal capacity. We face equally significant barriers within our individual contexts to model how we integrate the scientific evidence of our discipline within our current practices. We need to continue to foster the culture of research we have come to value and depend upon to inform our work in providing continuing education for physicians.

The recent and future work of the Research Committee and the Research Endowment Council will be pivotal as we continue to move forward to promote, support and encourage academic activities within the Society. For example the Research Committee is examining strategies to promote collaboration, mentorship, and partnerships to enhance research. Some of the options being actively considered include: enhancing the RICME sessions at our Spring and Fall meetings to provide a more in-depth critique of junior researchers' projects by selected senior researchers; enhancing the value and impact of the Summer Research Institute planned for June 2005 in Halifax; providing assistance and mentorship in such areas as writing grant applications and designing research projects; establishing an inventory of our members' research interests and skills; and examining opportunities to enhance participation in CME research through multi-site studies. The Research Endowment Council is in the process of creating an overall strategic plan to enhance research within the Society. This careful analysis has helped to identify our core goals and priorities in continuing education research and has explored the options available to us in relation to fund raising.

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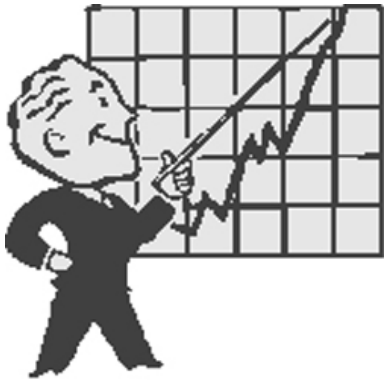
It is the dedication and commitment of these groups and their leadership that is most impressive to me and will ensure that we maintain and enhance our leadership role in academic CME. As these plans and ideas are discussed within the Society, I encourage you to take an active role in contributing to this aspect of our organization's life. If you are thinking about doing research but simply do not know where to start, there is a wealth of individuals in our Society who will help you and mentor you along the way. If there is an area of research that you are interested in, please let us know so that we can put you in touch with other individuals with similar interests. If you have ideas about fund raising to enhance our capacity to fund research we would like to hear from you. It is indeed an exciting time to participate in the life of this organization.

Biennial Survey Report for 2004 Documents Medical School Trends

By R. Van Harrison, Ph.D.



Continuing medical education offices and personnel share an overall mission to ensure that high quality CME programs are developed and produced at medical schools. The biennial survey collects and disseminates information about policies and practices relating to CME at colleges/schools of medicine in the United States and Canada. The Society currently has members at 104 of the 142 medical schools in the U.S. and Canada. Survey forms were completed for 71 schools, an institutional response rate of 68%. The results continue to demonstrate diversity across medical schools.

Current Trends

Modest increases were reported for the quality and number of courses. Modest decreases are reported for financial support from the university and for time between registering and the course date. For the other items (for example, attendance, faculty interest in CME, commercial support), the overall trend is close to no change.

The patterns tend to be somewhat consistent across years for most measures. A trend for ongoing slight increases is evident for quality of courses, number of courses, and possibly for faculty interest in participating in their school's CME. Generally stable are the number of external physicians per course, attendance at "pleasure" locations, and faculty interest in participating in other sponsor's CME. Generally decreasing are financial support from the university and the advance time for registration. The most variability across years is in financial support from commercial companies.

Programs and Attendees

Regarding live, in-person courses for external physician attendees, in 2002–2003 the typical (median) medical school produced 65 courses with 705 hours of credit and had an annual attendance of 3,248 physicians and 1,500 other participants. Each of these numbers is a slight decrease from two years ago.

Other forms of live CME for external audiences vary in their prevalence across medical schools. Half (49%) of medical schools arrange presentations at county medical societies and local hospitals. One-third of schools offer individual tutorials or traineeships. A minority of medical schools broadcast live conferences by television (22%), telephone (20%), or Internet (13%). These numbers have been consistent in recent years.

Regarding self-study CME activities, 80% of medical schools offer self-study activities: 68% in written form, 62% Internet, 42% computer disks, 33% video, and 21% audio. Schools that offer self-study activities typically produce fewer than ten self-study activities per year. The number of schools producing self-study activities did not change appreciably in recent years, but the number of activities by Internet, computer disk, and written material appears to be increasing and the number by video and audio appears to be decreasing.

Virtually all schools designate credit for some ongoing multiple session internal activities such as grand rounds. The median is 37 activities for a total of 808 credits, with schools varying widely on these numbers. The majority of schools designate credit for a few single occasion internal activities. The median is one activity for eight credits. These numbers are fairly stable across years.

Course Fees

The usual fee per credit hour ranges widely across medical schools. Fees for courses at the institution's primary location (median of $18/credit hour) are similar to recent years. Fees for courses at "pleasure" locations (median of $27/credit hour) are also similar to recent years.

Research in CME

Research is being performed in 24% of medical school CME units. Approximately one-quarter to one-third of medical schools are involved in each of the following: CME unit personnel doing CME research based in other units, personnel based in other units doing CME research, CME personnel doing research on other levels of medical education, and CME personnel doing research on topics other than medical education. The involvement of CME units in research decreased slightly over previous years, including the typical senior staff time devoted to it and the level of funding obtained for it.

Relationships with Commercial Companies

While medical schools vary widely in the number of courses receiving commercial support, the typical (median) medical school received support for 39 courses, representing 70% of the school's CME activities. This is similar to the amounts four years ago. The typical school received $500,000 in support, representing 45% of the school's course revenue. The amount of support is an increase over four years ago.

The typical school offered four courses supported solely by one company, representing 5% of the school's courses. If commercial support were no longer provided, the typical school would no longer hold 15 courses, representing 23% of the school's courses and a loss of 1,500 attendees. Similar amounts were reported four years ago.

The majority of live broadcast CME activities and self-study CME activities are predominantly supported by commercial funds: telephone conferences, single session televised conferences, live Internet broadcasts, written self-study, audio self-study, and computer disk self-study. Approximately half of the following do not receive commercial support: televised conferences with multiple sessions, tutorials or traineeships, video self-study, and Internet self-study.

Support is most often provided as a general grant to a course, for speakers' expenses, and for food and refreshments for course participants. The frequency of the purposes for support is similar to the recent past.

While virtually all medical schools responding to the survey accept financial support from commercial companies, some policies regarding the support vary appreciably between medical schools. Approximately half of the medical schools have policies that courses involving communication companies may be sponsored, all funds must pass through the CME office, university honoraria guidelines take precedence over company guidelines, and courses must have a token fee. The findings are similar to those four years ago.

The majority of schools find that commercial companies are "often" timely in signing letters of agreement, timely in paying funds, and have processes making it easy for the CME unit to compose letters requesting funds from the company. The values are slightly lower than four years ago.

The survey asked respondents to rank 15 pharmaceutical companies on a 5–point scale (1 = low to 5 = high) on knowledge of CME requirements and processes, adherence to national guidelines, and ease with which to work. The means of scores ranged from 3.2 to 4.3 – all above the midpoint of the scale. A company's score on "knowledge" generally paralleled its score on "adherence." The scores for "ease" were less closely related to the other two measures.

Approximately half of medical schools held commercially funded "satellite" meetings in conjunction with meetings of national specialty societies. The "satellite" meetings were typically initiated and managed by communication companies, involved "a little" problem with oversight and management, and did not reduce funding for regional CME activities. The results are similar to those four years ago.

Communication Companies

Three-quarters of the medical schools currently work with communication companies. Medical schools have a wide variation of experiences in working with these companies, with typically "somewhat" of a problem with short time constraints and "a little" problem with faculty contacts, with the company following approval processes, and with budget control. Schools that are working with communication companies vary appreciably on whether they like to work with this type of company. The results are similar to those four years ago.

Most medical schools will sponsor an activity with a communication company if a member of the school's faculty is the activity director. The majority will sponsor an activity if a member of the school's faculty is on the presenting faculty or is at least reviewing an activity.

AMA PRA Credit to Non-U.S. Physicians

The AMA now requires U.S.-based accredited CME providers to obtain written permission from the AMA in order to award AMA PRA category 1 credit to non-U.S. licensed physicians. The majority of schools have not requested this permission. Approximately one-third have requested it for some live, in-person courses and approximately 10% for various types of self-study activities.

CME Involvement in LCME Accreditation

For medical schools that had their medical student education program reaccredited in the past two years, this year's survey asked about the involvement of the CME unit in that reaccreditation process. At all schools the CME leadership or unit provided information about the CME program as part of the institutional self-study process. The substantial majority also provided some information during the reaccreditation site visit.

Priorities for the CME Program's Mission

This year's survey asked several questions about priorities related to the mission of the overall CME program at the medical school. The most striking finding across all items is the broad distribution of responses. This demonstrates a general lack of consensus regarding importance of the possible priorities listed in the survey. The two most highly rated activities are applying evidence-based education research in CME delivery and emphasizing quality improvement practices. The two most important barriers are lack of funding for outcomes-based CME activities and limited time to make CME more effective. The four most important methods are educational interventions to change knowledge and skills and to improve performance, evaluation methods, and needs assessment in the practice setting. None of the listed tools and resources have high mean ratings on importance.

The 2004 Survey Subcommittee of the Society Research Committee was chaired by R. Van Harrison, Ph.D. Members included John R. Boothby, M.S.W., Craig M. Campbell, M.D., Michael Fordis, M.D., Martyn O. Hotvedt, Ph.D., John R. Kues, Ph.D., Paul E. Mazmanian, Ph.D., and Janet Z. Temple, Ph.D.

The full report of the survey results is available at www.sacme.org under "publications."

News from the Program Committee: Fall Meeting Planning Under Way

Interest in the Society's Program Committee work has increased this year as a direct result of recent dynamic and relevant hot topic sessions that have increased attendance at the past two national meetings. Attendance at the Program Committee meeting at the CME Congress in Toronto was at an all-time high as is participation in the committee's listserv discussions. Leslie Aguayo has agreed to serve as the new Vice Chair of the Program Committee and will work with Melinda Steele, M.Ed., the current Chair, through the Fall meeting when she will take over as Chair.

The Program Committee began working on the Fall program just before the Congress in Toronto. Productive discussions during the meeting in Toronto narrowed the range of topics to a good blend of issues. Although specific topics and speakers have yet to be identified, the focus will be on research ethics and professionalism, ethics in journalism related to research, ethics and professionalism regarding commercial support, the status of commercial support issues, and resolving conflict of interest. The Program Committee will make every effort to engage nationally known speakers and to pair some of the topics and speakers in panel discussions or debates. The Fall meeting, held in conjunction with the AAMC meeting, will take place November 5 -7, 2004 in Boston. The Society's meetings are scheduled to take place in the Marriott Copley Place and the Hynes Convention Center.

The Program Committee also began work on developing a request for proposal process for selecting host institutions for Spring SACME meetings where contracts have been signed with resort properties. The first of these to elicit proposals to host the Spring 2007 meeting at Copper Mountain, Colorado, should be released in the Fall of this year.

CONGRESS 2004: EXCITING, MEMORABLE, ENJOYABLE

By Lee Manchul, M.D., MHPE

Bravo to the Congress 2004 planning committee and Scientific Program Committee for their success in producing an outstanding and memorable international conference for continuing medical education professionals, "How Continuing Medical Education Helps Translate Knowledge into Practice", held in Toronto from May 15-18, 2004. Thanks to Dave Davis, M.D. and the University of Toronto staff for choosing such a wonderful venue, the Fairmont Royal York Hotel, and such a terrific city in which to host a meeting for CME professionals. Congratulations to R. Van Harrison, Ph.D., Chair of the Scientific Program Committee and the committee members for putting together a thoughtful and provocative program. Five keynote speakers, 15 symposia, 20 workshops, 42 research presentations, and 54 posters provided an expansive overview of current issues in CME and challenged CME providers to develop strategies to translate knowledge into practice within the current health care, regulatory, and social environments.

Plenary Sessions

The high caliber of the plenary presentations and the insightful commentary was reflected in the rapt attention of the standing room only crowd and in the thoughtful questions that followed the plenary speakers. Mark Smith, M.D., M.B.A., President and Chief Executive Officer, California Health Care Foundation, Oakland, California, stressed the importance of a paradigm shift in terms of the traditional understanding of CME delivery and outcome evaluation. Physicians (and other health care professionals) do not learn in isolation, but work and learn in teams; physicians need to learn how to harness software technology to deal with volumes of data; and, physicians must learn how to practice within increasing financial constraints. Thus, CME must encompass behavioral research and teamwork skills, communication skills, the use of technology in medicine, how to deliver cost effective health care, and learning within communities of practice within the workplace.

Raj Mangrulkar, M.D., Clinical Assistant Professor of Medicine and Associate Residency Program Director, University of Michigan, provided a thoughtful presentation on strategies to promote evidence-based decision making at the point of care. He stressed the need for teaching within the context of clinical care, promoting reflection on clinical issues, and providing strategies to optimize the use of electronic resources tailored to the learner.

Karen Mann, BN, M.Sc., Ph.D., Director of the Division of Medical Education, Dalhousie University, Halifax, Nova Scotia, provided a lovely overview of educational theory in CME and described how it has (and has not) helped continuing medical educators. She reviewed essential aspects of constructivist (knowledge-building), behaviorist (practice and feedback), cognitive (past experience influences learning), social learning (motivation to learn) and humanist (self-direction and reflection) theories and described how they relate to understanding how professionals learn. She emphasized that no one theory fully explains and informs practice, but many aspects of educational theory can be incorporated into educational models for CME.

Jeremy Grimshaw, M.B., Ch.B., Ph.D., Director, Clinical Epidemiology Program, Ottawa Health Research Institute and Director of the Centre for Best Practice, Institute of Population Health, University of Ottawa, described the consistent failure to translate research results and clinical guidelines into clinical practice. He described financial, organizational, and professional barriers to evidence-based practice and provided strategies that need to be adopted in order to implement evidence-based clinical practice broadly. He outlined some of the problems with previous "systematic" reviews (multiple interventions, reporting bias, heterogeneous outcomes, lack of statement of effect size) and provided an overview of his recent systematic review of single intervention studies of guideline dissemination and implementation strategies. The result? Single interventions can be as effective as multi-faceted interventions, and reminders are the most consistently effective strategy to implement guidelines.

Concurrent Mini-symposia

A number of concurrent mini-symposia delivered by experts in the field of CME provided a wide variety of current hot topics, including the impact on practice of innovations and regulation in CME and CPD (Dennis Wentz and Lewis Miller), documenting the impact of CME on clinician behavior (Dale Moore, Hank Slotnik, James Leist and Don Moore), the AMA experience in performance measurement and improvement (Steven Minnick and Charles Willis), repositioning for excellence in CME (Bruce Spivey, Bruce Bellande, and Marcia Jackson), the role of CPD in revalidation of physicians (Daniel Klass, Dan Faulkner, Elizabeth Wenghofer, et al.), controversies and concerns about CME funding (R. Van Harrison and Michael Saxton), the evolution of web-based CME (Linda Casebeer, Bob Kristofko, Michael Fordis, Nancy Bennett, and Sheryl Strasser), and alternative funding strategies for CME (Jack Kues and Melinda Steele).

Concurrent Workshops

Concurrent workshops spanned the continuum of CME: integrating clinicians' information needs into CME (Allen

Society members actively participated in all aspects of Congress 2004. Clockwise from upper left: Dennis Wentz, M.D. receives the Distinguished Service in CME Award from Gloria Allington, M.S.Ed.; Susan Duncan, M.Ed, C.M.P. receives a certificate of appreciation for service as Membership Chair from President Nancy Davis, Ph.D.; Paul Lambiase and Barbara Mierzwa, M.S."man" the Society's exhibit table; Dave Davis, M.D., hosted the Congress and delivered welcoming remarks; new member orientation was well attended; and Jan Temple, Ph.D. received a certificate of appreciation from President Nancy Davis, M.D. for serving as Chair of the Research Endowment Council.

Shaughnessy and Mark Ebell), the interface between research and practice in CME (Jocelyn Lockyer and John Toews), the essentials of conducting randomized controlled trials in CME (Dave Davis, Suzanne Ferrier, Michael Allen and Mary Bell), creating and evaluating interprofessional CME initiatives (Lee Manchul and Gary Sibbald), incorporating best practice CME to improve quality of care (Réjean Laprise, Linda Snell, R. Van Harrison, Dave Davis, and Marty Hotvedt), using educationally influential clinicians to enable knowledge transfer (Rhonda Reardon and Jane Gibson), enabling traditional care delivery teams to function as communities of practice to create an enhanced learning environment to promote practice improvements (Robert Thivierge, John Toews, Carter Mecher, John Parboosingh, et al.), facilitating knowledge translation in CME program development (Curtis Olson, Lorna Cochrane, and George Mejicano), enhancing end-of-life care through communication skills workshops (Daniel Keatinge and Denise Lenore), designing best practice on-line CME courses (Fran Kirby, Cynthia Gardiner, Robert Glynn and Lisa Wells), enabling knowledge translation through technology (Robert Thivierge, Tunde Gondocz, David Ryan, et al.), team learning in CME (Kathryn McMahon, Nancy Searle, and Melinda Steele), and practical applications of change theory in quality assurance initiatives (Tom McKeithen and Chris Larrison).

Research Presentations

The forty-two original research papers that were presented demonstrated the broad range of original research, scholarly activities, and demonstration projects carried out by members of the sponsoring organizations and participants. They reported results of research that studied innovative means of promoting a change in practice including systematic reviews of randomized trials, the role of formalized personal learning projects, the role of opinion leaders in CME, commitment to change instruments, the role of question-asking skills and personal learning project enablers in promoting change in practice, and the role of reflection in implementing learning into practice. Other studies evaluated the effects of videoconferencing, the influence of the Internet on practice, and the role of technology in determining physicians' educational needs. Several studies provided new conceptual models of professional learning and change and, in particular, how professionals acquire and apply new knowledge.

Thanks and kudos to the Congress 2004 organizers, the presenters, the sponsoring organizations and the participants for providing a truly exciting, memorable, and enjoyable CME event.

Canadians Win Awards for Projects and Research

The Fox Award honors the research of Dr. Robert Fox, University of Oklahoma, who has contributed greatly to the literature in the field of professional continuing education. Each year the Fox Award is usually presented to the SACME member whose RICME abstract is judged best with respect to its methodology and impact on the profession. The awardee this year was selected from presentations at Congress 2004 by a committee chaired by Barbara Barnes, M.D.

The winner was Tara Kennedy from the University of Toronto for the following paper: Kennedy T., Regehr G., Rosenfield J., Roberts S.W., and Lingard L. "Degrees of gap between knowledge and behavior: a qualitative study of clinician action following an educational intervention." The paper has been published in *Academic Medicine*, 2004; 79(5):386-393. The selection committee's criteria were based on original, empirical research addressing an important issue in CME. They were particularly interested in innovative projects that will add to the literature and will help to inform theory.

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The Journal of Continuing Education in the Health Professions Editorial Award for Excellence in Research was announced at Congress 2004. Awarded annually since 1995, and until this year called the Decker Periodicals Prize, the award recognizes and encourages superior original research and scholarship in the field of continuing education in the health professions.

The winner was Jacqueline Wakefield and her colleagues for the following article: Wakefield J., Herbert CP, Maclure M., Dormuth C., Wright J.M., Legare J. et al. "Commitment to change statements can predict actual change in practice. *JCEHP*, 2003; 23(2):81-93.

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Lee Manchul, M.D., MHPE won the 2003 Best Master of Health Professions Education Thesis Award, an award sponsored by the Department of Medical Education of the University of Illinois at Chicago College of Medicine. Her project, "Interprofessional Education and the Radiation Oncology Team: Benefits, Needs, Organizational Challenges", won on the basis of its relevance to medical education, innovation, comprehensiveness, and methodological and writing clarity. Dr. Manchul received her award at a special awards reception in Chicago last July.

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Retracing Our Roots – A Series of Interviews with SACME Founders and Leaders

Jack L. Mason, Ph.D. was President of the Society from 1991 to 1992. In addition to being a long-standing member and leader of this organization, he is known for his keen wit and outgoing personality. Whenever you encounter him, you can be sure that he will be prepared with several jokes that are guaranteed to make you forget about the trials and tribulations of administrating an academic CME department. He was interviewed in the Fall of 2003 by Barbara Barnes.

BB: How did you become involved in CME?
JM: I joined the office of Medical Education at the University of Maryland in 1974 and a year later we obtained a three-year grant from the National Library of Medicine to study the "Information Needs of Practicing Physicians". This project was very timely as an increasing number of state and specialty societies were requiring CME participation for physicians to remain in good standing in their respective organizations. The target audience for our study was all private practice physicians in Maryland. Surprisingly, 646 physicians completed our questionnaire which required about an hour of their time. The final report was 190 pages and contained a wealth of information regarding physicians' preferences for obtaining their CME. As a result of participating in this study I developed a deep interest in CME. I don't know if there is a connection but in 1977 I was offered the Assistant Dean for CME position which I happily accepted. As a footnote, Dennis Wentz had held this position but left two years earlier to become involved in the University Hospital Administration.

BB: When did you become involved in the Society and how did it support your career?
JM: I was a post-doctoral fellow in medical education with Steve Abrahamson at the University of Southern California in 1969-1970 and became acquainted with a number of medical educators. After the excitement of being named CME Dean subsided, I wondered how to approach my new position. I contacted some folks I knew and asked for their advice. Through this process I became aware of the Society and attended their next meeting which was part of the annual AAMC meeting. I had met Phil Manning at USC and he introduced me to everyone. My early and subsequent involvement with the Society contributed immensely to my career in two ways: (1) the Society meetings provided me with information about new developments and trends in CME and (2) the sharing, collegial nature of the Society sustained me through some very difficult times and I wish to thank everyone I met over the years for their helpful suggestions and support.

BB: Was the Society different in those days?
JM: In my opinion, yes. In the late seventies-early eighties the CME focus was on improving course offerings and income generation. Many of us were facing self-support directives from our Deans because the feeling was that with the advent of mandatory CME, there was a large audience of physicians eager to pay for participating in certified activities. A large portion of the programs at the Society meetings was focused on practical matters such as methods of needs assessment, marketing, evaluation, and commercial financial support. Another matter of importance was the increasing complexities of reaccreditation and how the requirement could be met with limited staff and budget. The years in which my office was due for reaccreditation were filled with much extra effort and considerable anxiety. I suspect the reaccreditation process still evokes thoughts of finding a new line of work for some CME directors.

Jack L. Mason, Ph.D.

BB: What hasn't changed?
JM: I attended some of the sessions at the Society meeting last Fall and I was impressed with the still increasing constraints and additional requirements associated with contemporary CME. I was also impressed with the professional demeanor of those in attendance. I knew that appropriate ideas and strategies for coping with the new requirements would be developed and shared with colleagues starting with the evening social event. It was also comforting to see that Van Harrison continues as an outstanding presenter.

BB: In your view, what have been some of the major accomplishments of the Society?
JM: During the past 27 years the Society has grown and matured as a professional organization. When I joined the Society, everything functioned because of many well intentioned volunteers and on a shoestring budget. Now the Society has a well established legacy, professional

management, a regular newsletter (*Intercom*) and is widely recognized as the organization for academic CME. I agree with John Parboosingh that the Society provided a focal point for the development of RICME. An academic society must encourage and support relevant research and the considerable efforts of Dave Davis, Bob Fox, Jocelyn Lockyer and Paul Mazmanian and several others have made this possible. Jim Leist and others facilitated the establishment of the very necessary Research Endowment. I also feel that the occasional CME Congress, originally organized by Phil Manning in 1988 provides a major indicator of the Society's success.

BB: How did you approach your presidency?
JM: Before becoming President I served two years as Secretary-Treasurer which required a considerable amount of time and energy from me and my secretary, Althea Pusateri. One of my goals was to separate the functions into two different positions. This was finally realized in 1994 when Paul Lambiase became Treasurer and Marion Anderson became Secretary. Another issue at the time was the somewhat competing presence of the Alliance for CME. There was even talk that maybe we should merge our Society with the Alliance. I felt that academic CME had its unique mission and we should continue on our own. Many others agreed and we maintained our independence but still consider the Alliance as a colleague rather than a competitor. I attended several Alliance meetings and remember the workshop on Industry-CME Relationships that Bob Kristofco and I presented at their 1989 meeting. After my presidency was completed I served as chairman of the Nominating Committee. I was very proud when we nominated Gloria Allington who later became the first female president of the Society.

BB: How has the Society influenced your career?
JM: As I said earlier the Society programs were a continual source of new information and ideas. Also, Society members were always willing to share their experiences and offer suggestions. Whatever success I achieved as a CME administrator was due at least in part to my association with the Society. I was always proud to be a member of the Society because its existence and activities made me feel like a true professional person.

BB: What is your vision for the Society?
JM: The Society should continue what it is doing and always be seeking to provide its members with the latest relevant information and be a source of assistance with all the challenges that face those who work in academic CME. I also hope that the Society continues to attract the competent and dedicated leadership that I saw during my career.

News from the American Medical Association

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

Here in Continuing Physician Professional Development (CPPD) we are preparing to revise the AMA PRA credit system in order to accommodate interactive, practice-based learning, while the drum roll continues from all quarters to observe and validate physician performance according to normed standards. The timing could not be better. The two principal CPPD pilot projects conclude their work this year, and adoption by the AMA Council on Medical Education of their complementary recommendations will recognize, for the first time, learning outside the static needs assessment/learning objectives model of traditional CME. Although the latter has its place as an educational platform, we sought to establish learning modalities that reduce the distance between education that takes place "out there" and satisfying the educational needs continuously defined by a physician in active practice.

Both pilots have been previously described by Dr. Dennis Wentz, physician-directed interactive Internet CME and performance measurement (now improvement) pilots. At the recent CME Congress, R. Van Harrison, Ph.D. in his overview slotted both of these initiatives into his schematic of how physicians translate knowledge into practice: information, education, and then implementation.

The information domain ties to Internet CME, where physicians search the professional literature for specific diagnostic and therapeutic information. Despite the teething problems associated with point of care electronic decision support tools (also discussed at the Congress), the breadth of clinical information and the increasing sophistication of search technology will continue to stimulate development of these

applications. Physician directed Internet CME will award AMA PRA category 1 credit for this type of learning. As a former librarian, who fifteen years ago attended a presentation on hypertext links and the Internet, I saw this development would revolutionize our work. Outside of major holding libraries, the days were numbered for staff assiduously reshelving journals after use.

Dr. Harrison treated the education domain as the area where "experts synthesize and prioritize new information" or what we know as traditional CME activities.

We hope capturing performance improvement activities for AMA PRA category 1 credit will serve the implementation domain where physicians "put [knowledge] into practice in [a] local context." In this arena, documented performance change can further both the quality and patient safety agendas by using criterion or self-referenced standards.

This framework nicely describes our first effort to close the loop wherein the AMA PRA credit system on the one side recognizes learning associated with physicians probing the clinical literature, and on the other links lessons learned from both the information and education domains to the implementation of performance change in physician practice.

Performance Improvement: A Model

The AMA performance improvement pilot project has concluded three years of work with some basic recommendations on how to structure this activity. Performance improvement efforts in this setting should offer physicians and the rest of the health-care team enough flexibility to attack a broad range of performance gaps. These include not just tracking performance in the management of chronic disease, where physicians present as the obvious key players, but also systemic issues such as communication and patient education.

At the Congress, Barbara Barnes, M.D., who led one of the performance improvement pilots at the University of Pittsburgh Medical Center, discussed a focused performance improvement activity at Pittsburgh to raise compliance with hand-washing standards. This intervention required no molecular biology, but was so important and included all members of the clinical care team.

Our proposed performance improvement cycle will be instantly recognizable to all of you as an adaptation of Deming's work with industrial quality improvement. In the foreground we placed knowledge of and background in the selected standard. (We started with four stages but shrank it to three, with the latter component melded into the first stage.) The stages break out as follows:

Stage A: Learning from standard identification and current practice performance assessment (retrospective)

Stage B: Learning from the application of performance improvement to patient care (prospective)

Stage C: Learning from the evaluation of the performance improvement effort (reflection)

CME providers remain central players in this, expected to leverage their existing expertise to develop modules and materials that physicians can use to dynamically assess and improve their practice. Physicians who can document their prior work can enter at any stage, although we propose a final, or maximum quanta of credit for physicians who complete all three stages of a well designed performance improvement activity. The steering committee believes this sequence offers the best chance for reflection and change.

A blizzard of details remain, the toughest of which is documentation requirements. These should be robust enough to establish face validity but not so onerous as to discourage physician participation. Documentation for a thoughtfully done performance improvement activity should communicate genuine curiosity about the process and address system issues without abandoning personal responsibility for improvement. Only as an organized "reflection on practice" will performance improvement activities succeed and not degrade into a box-checking exercise. In this way, practice change and improvement can emerge from within the profession. "The outsider can judge care, but only the insider can improve it."*****

The AMA Council on Medical Education will consider AMA PRA language for performance improvement activities at the September meeting. Upon approval, CPPD will promulgate these guidelines. As always, we welcome your comments and feedback.

***** Berwick, DM. Eleven worthy aims for clinical leadership of health system reform, *JAMA*, 1994, 272(10): 797-802.

Congratulations to Jim and Chi Ranieri on the birth of their daughter. Gabriella Barbara was born on May 16, 2004.

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UPCOMING EVENTS

July 30-31, 2004
CME: The Basics
Rosemont, Illinois
Website: www.acme-assn.org

August 1-2, 2004
Understanding ACCME Accreditation
Chicago, Illinois
Contact: ACCME (312) 755-7401

September 27-30, 2004
15th 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

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