The Society for Academic Continuing Medical Education
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INTERCOM

THE SOCIETY FOR ACADEMIC CONTINUING MEDICAL EDUCATION

SACME 2004 Fall Meeting Program Highlights Current CME Issues

The Fall SACME meeting will be held in Boston November 5-7, 2004, in conjunction with the annual meeting of the Association of American Medical Colleges.

Plenary sessions will include:

- Consequences of Unprofessional Behavior in Medical School (Maxine Papadakis, M.D.)
- Models of Integrating Core Competencies into CME Practice with Emphasis on Topics of Ethics and Professionalism (Discussion Panel with Case Studies and Examples)
- Strategies for Collaborating with Industry Effectively and in Compliance with the PhRMA Code, Standards for Commercial Support, and FDA Guidelines (Maureen Doyle Scharff and Mike Saxton, M.A.)

Additional topics include

- AAMC's Institute for Improvement in Medical Education
- Credit for Practice-based CME (Nancy Davis, Ph.D. and Charles Willis, MBA)

Members and others will be presenting research and best practices n CME. CME Outcomes Assessment: Exemplar Programs will be the topic of the jointly sponsored session with the Group on Educational Affairs CME Section that will be held on Sunday, November 7. It will be moderated by Lee A. Manchul, M.D. and include presentations by Barbara Barnes, M.D., Ellen Cosgrove, M.D. and Richard (Van) Harrison, Ph.D.

SACME sessions will be held at the Boston Marriott Copley Place and the Hynes Convention Center. Full program information, registration, and links to the AAMC meeting and hotel reservations can be found on the SACME web page, as well as a list of AAMC sessions relevant and of interest to CME professionals. Prior to leaving for Boston, members are encouraged to check the web page for schedule changes, room locations, and other late-breaking details.

In This Issue

Dates Announced for Summer Institute for CME Research

The Society's Summer Institute for CME Research will be held June 25-30, 2005 in Halifax, Nova Scotia, Canada. The organizers are Craig Campbell, M.D., Joan Sargeant, M.Ed., and Michael Allen, M.D.

Designed both for novice and experienced CME researchers, the Institute enables participants to select learning activities of most value to them at their particular level of research skill and knowledge. The program offers:

- Presentations on the core principles and processes of educational research
- Mini-workshops to explore topics in depth and practice skills
- Individual consultation with skilled researchers about participants' proposals or studies
- An opportunity for participants to develop their own research proposals and studies

Organizers stress that June is a wonderful time to be in Halifax and that participants will not only work and learn but will also be able to enjoy the ambience of the friendly city, the sea breezes, the beaches, and the seafood.

Discounted registration fees will be available for SACME and Alliance for CME members. Information on the Institute will continue to be updated on the Society website: http://www.sacme.org.

From the President

By Craig M. Campbell, M.D.

Over the past several months I have had several conversations with colleagues to encourage them to consider becoming members of the Society. These discussions have caused me to reflect on my own views of the purpose and roles of the Society. What defines us as unique from all other relevant CME organizations? What defines us as distinct from all other relevant CME organizations? What makes us different? Why does that matter?

If we did a survey of our membership on these types of questions I suspect the results would reflect a variety of answers linked to the varying scope of our contexts as CME professionals and the breadth of our activities as a Society. During our recent annual leadership retreat in August 2004 in Ottawa, the leadership group had an opportunity to begin the process of defining a general strategic plan for the Society over the next several years. Implicit to these discussions was arriving at some conclusion about what defines our purpose and goals, and the opportunities that we must pursue in the future to fulfill our core mission.

One way to see the Society is to understand the views of other organizations that have articulated leadership roles the Society can and should play based on our collective mission and expertise. Two such examples come to mind. The first is imbedded in the Conjoint Committee on Continuing Medical Education report. This report, drafted by 13 key CME stakeholder organizations (including SACME) defined two key leadership roles for the Society. The first role is to establish a CME research agenda and dissemination strategies. This includes:

- Fostering a comprehensive research agenda in CME supported by all stakeholder organizations.
- Assisting and encouraging CME researchers in creating formal and informal networks to ensure rapid dissemination and adoption of innovations.
- Encouraging benchmarking commendable practices.

The second role defined for SACME is faculty development for physician educators. This broad area includes four sub-domains:

- Providing educational opportunities for CME professionals to become competent in the design and delivery of faculty development for physician educators.
- Creating faculty development opportunities that further physician educator competencies in evidence-based content, teaching presentation skills, principles and strategies to support physician learning, and methods to influence changes in physician behavior.
- Ensuring that the CME system assesses teaching skills of physician educators in a structured and informed manner; promotes effective teaching using a variety of modalities; and develops psychometrically sound evaluation instruments to measure the effectiveness of teaching skills.
- Offering recognition and reward systems (promotion and tenure) for physician educators who demonstrate effective educational skills.

The second example occurred during a teleconference between the leadership group and Michael Whitcomb and Deborah Danoff of the Association of American Medical Colleges (AAMC) during our leadership retreat in August. The purpose of the conversation was to explore potential roles the Society could play within the AAMC. Beyond the contributions of our membership to the CME Section of the Group on Educational Affairs, our conversation with Michael Whitcomb focused on the direct role the Society can have within the recently established Institute for Improving Medical Education. This new institute was established to respond to growing concerns about the quality of medical education in the United

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States across the educational continuum. Why was SACME being considered to contribute directly to this new institute? In part it was based on our commitment as an organization to academic excellence in continuing education of practicing physicians.

In my mind what makes us unique is our commitment to innovation, collaboration, knowledge generation through research, and the translation of research findings into our practices as health professionals. We are the benchmark organization when there is a question of understanding the research literature or establishing new knowledge related to how physicians learn and change and the effectiveness of CME interventions on the process and outcomes of learning, improvements to quality of performance and care, and enhancements to health care outcomes. Our efforts in advocating for the Society and our demonstrated commitment to excellence is opening up opportunities for us to make a difference not just on the practice of continuing education but in the development of policy and standards that influence that practice. It is our commitment to the pursuit of academic excellence in CME that serves as the basis for the development of our strategic planning processes to define the Society's research agenda. It is the basis of the efforts of our Research Endowment Council in developing fund raising strategies to expand our resource capacity to support research initiatives of our membership. It serves to inform the mission and activities of our research committee in advocating for the development of empirical research in continuing professional development and the ongoing improvement and development of continuing professional development research professionals. It informs our approaches to advocacy—how we can expand our membership from within our medical schools and specialty societies and how our meetings can serve to enhance discussions surrounding the key issues influencing our discipline.

You will certainly be hearing more about these developments as they unfold. It is indeed an exciting time to be a member of the Society. I look forward to seeing you at our Fall meeting in Boston in November.

Spring Meeting 2005 Promises a Dynamic Program Coupled with an Outstanding Location

Planning is under way for the SACME Spring Meeting that will be held April 14-17, 2005 at Lakeway Inn Conference Center and Resort at Lake Travis near Austin, Texas. Texas Tech University Health sciences Center in Lubbock, Texas will serve as the host institution. In addition to a spectacular program, the recreational opportunities are outstanding. Additional information will be available at the Fall Meeting in Boston, on the Society website, and in upcoming mailings to the listserve.

Lakeway Inn Conference Resort
Lake Travis • Austin, Texas

Industry Changing Procedures for Providing Educational Funding

By R. Van Harrison, Ph.D.

Several major pharmaceutical companies are changing their procedures for providing funding to support medical education activities, including CME (society meetings, regional courses, local grand rounds) and resident education. Makers of medical devices are also planning changes.

Forces Producing Changes

During the past decade pharmaceutical companies greatly increased their marketing expenditures, including gifts to support educational activities related to products of the company. In recent years federal agencies began investigations into the legality of these expanded activities. Although the following information focuses on pharmaceutical companies, the same laws apply to medical device manufacturers, who are also making changes.

The federal "anti-kickback" statute and the Federal Food, Drug, and Cosmetic Act are the most important laws for commercial support of medical education. Violation of either law can result in civil and criminal penalties for both the giver and recipient. (Companies have "deeper pockets.")

Anti-kickback statute. The much broader federal "anti-kickback" statute is a criminal prohibition against payments (in any form, whether direct or indirect) made purposefully to induce or reward the generation of federal health care business (e.g., referrals or prescribing) paid with federal funds (e.g., Medicare, Medicaid). Inducements may be associated with educational gifts, research grants, consulting, and other arrangements involving physicians. Inducements may take many forms beyond a direct payment for favorable treatment, such as payments higher than fair market value for services or eliminating expenses that physicians would otherwise incur.

Food, Drug, and Cosmetic Act. The labeling and advertising provisions of the act require that companies do not promote unapproved uses of FDA-regulated products. Direct or indirect company control over an educational activity makes the activity subject to the advertising restrictions placed on the company. In 1997 the FDA issued a Guidance for Industry: Industry Supported Scientific and Educational Activities (www.fda.gov/cder/guidance/isse.htm). This guidance identifies factors that distinguish activities influenced by a company from independent activities receiving support from a company.

In April 2003 the Office of Inspector General (OIG) of the Department of Health and Human Services issued a Compliance Program Guidance for Pharmaceutical Manufacturers (oig.hhs.gov/fraud/complianceguidance.html). The guidance makes several recommendations regarding how pharmaceutical companies should operate to assure that funds provided by a company are not used inappropriately to influence the purchase of the company's products. These recommendations are a major force in directing the specific changes currently being made by several companies.

As federal costs for pharmaceutical expenditures have increased, the federal government has been increasingly active in investigating and prosecuting pharmaceutical companies under the anti-kickback statute. Federal investigations of almost every major pharmaceutical manufacturer are currently under way, including multiple investigations of some companies. The penalties are very high. In 2001 Tap Pharmaceuticals Products paid $875 million, in 2003 AstraZeneca paid $355 million, in 2004 Warner Lambert (now part of Pfizer) paid $430 million and Schering-Plough paid $346 million. Each company also pleaded guilty to criminal charges. (One investigation included medical schools in the Boston area receiving subpoenas to provide records of funding received from pharmaceutical companies.) Additionally, several state attorneys general have filed suits against companies.

Investigations and legal scrutiny are expected to intensify in future years. As new federal Medicare drug benefits are implemented, financial incentives will increase for the government to uncover marketing manipulations that illegally increase the cost of drugs and recover inappropriately obtained income plus additional punitive financial awards.

Changes Under Way

Attorneys at companies manufacturing drugs and medical devices are recommending that their companies reorganize business processes proactively to minimize the company's likelihood of violating the anti-kickback statute. While none of the settlements to date involve kickbacks associated with commercial funding for CME activities, both the OIG and commercial companies recognize the potential for abuse involving CME. The OIG guidance addresses pharmaceutical support for independent educational activities, including having units other than sales and marketing make decisions regarding funding and basing funding decisions on explicit criteria that help assure that the funding award will not provide unusual benefits likely to induce inappropriate recommendations or prescribing. However, the OIG guidance contains recommendations, not requirements. Companies vary in their interpretation of the guidance and how to implement recommendations. Restrictions on restraint-of-trade prevent several companies from jointly agreeing on interpretation and implementation. Some companies have moved quickly to implement major changes. Other companies have changes under way, but at a slower pace. Still other companies are waiting to see the results of changes elsewhere before making major changes.

As of August, 2004, five pharmaceutical companies have rapidly implemented fairly

strict interpretations of the guidance: Merck, Aventis, Centocor, Bristol-Myers Squibb, and Eli Lilly. Additional companies (e.g., AstraZeneca, Wyeth) have announced that changes will occur this fall. Across these companies the following changes are typical.

Sales representatives can no longer provide educational gifts. Companies are assigning responsibility for decisions on financial gifts to a company unit responsible for educational, professional, or legal functions. Each company has established a central intake point for all requests for educational grants. Central Internet sites for receiving requests have been established by Merck (www.ce-support.com) and Aventis (www.aveedugrants.com). Central phone numbers have been established by Centacor (800-746-6998), Eli Lilly (877-545-5946), and Bristol-Myers Squibb (imaging 978-671-8217, oncology 609-897-2591, virology 609-897-2080, all other 609-897-2335).

Sales and marketing personnel retain the ability to make expenditures for sales activities. In general sales representatives can pay exhibit fees, pay for meals associated with company sales and promotional events (e.g., dinner meetings put on by the company under FDA guidelines), and similar expenses. Commercial exhibit fees in conjunction with educational events are commercial "fee for service" transactions. These transactions are separate from the application for a financial gift (educational grant) to help fund the activity.

Companies vary somewhat in the specific information they require with requests for educational support. Typically much of the following information is requested. Somewhat similar information is asked for other relevant activities, such as travel support for a resident.

- Activity title
- Date(s)
- Location
- Type of activity (e.g., grand rounds)
- CME credit hours offered (if applicable)
- Audience: discipline/specialty and size
- How educational needs were assessed
- Clinical topics (related to company's interests)
- Number of speakers (if applicable)
- Program format
- How activity will be evaluated
- Amount requested
- Are other companies expected to provide support
- Projected expenses by category
- Name of CME/CE provider and type of accreditation (e.g., by ACCME)
- Contact information for communications and for signing Letter of Agreement

Personnel who are not in sales or marketing review the requests against criteria established by the company and determine which requests will be funded. Companies vary somewhat in the criteria they use. Companies consider their specific criteria to be proprietary information. The following criteria are examples that are likely to be used by many companies.

- Availability of funds: funds for this period are still available
- Time frame: event is within the time period for which gifts are currently being decided; request is made sufficiently in advance of the event (e.g., 30 or 60 days in advance) for processing
- Relevance to company's commercial interest: specific clinical topic, audience
- Likely educational quality: needs assessment, format, evaluation
- Quality of CME provider (also any previous history of problems with a provider)
- Reasonable expenses for meeting type and number of participants
- Appearance of inappropriate financial inducement, e.g., unusually high honorarium levels, location at luxury accommodation or resort
- Match to company's national strategic plans for allocating funds, e.g., geographic distribution, types of activities, types of audiences, number of different recipients.

Both the company providing educational support and the institution receiving it generally sign a document stating that the recipient remains independent of influence from the company. This document, often called a Letter of Agreement, helps both parties. The Accreditation Council for Continuing Medical Education (ACCME) requires that CME providers have documentation of their continued independence when receiving funds from commercial sources. The guidances of both the FDA and OIG recommend that companies also have these documents to demonstrate they do not intend to influence the activity. No specific wording is required, but the general principles for these letters were established by the ACCME over a decade ago.

Companies are responding to the recent OIG guidance and increased scrutiny by adding more language to these agreements detailing limitations on the company. The document remains an acknowledgement of a gift from the company to the educational institution. However, many companies are adding text on limitations derived from the FDA and OIG guidances, making the documents appear more technical and complex than the usual gift acknowledgement.

Implications

Changes in funding procedures are having several effects.

- Past relationships with local sales representatives may have little impact on funding decisions.
- As an individual company changes its procedures, the transition often results in delayed funding decisions.
- Additional effort is typically involved in assembling information necessary to submit requests.
- Funding is less likely to be provided if it appears to be excessive, not educationally relevant, or to include financial inducements to the receiving organization, faculty, or participants.

The impact of these changes on overall availability of commercial funding is not certain. The most likely possibility is that overall funding will be reduced to some extent. Companies have to absorb the higher transaction costs associated with assuring and documenting that no inappropriate

influence occurs. More fundamentally, providing educational gifts through sales representatives often provided secondary access and recognition benefits to sales personnel. As these secondary benefits are eliminated, companies may reduce funding of educational support in proportion to its reduced overall benefit to the company.

Providers who anticipate requesting funding from drug or device manufacturers should be aware of the following:

- Do not assume that the process previously used to receive funds will continue.
- Check with relevant companies about their current policies and procedures.
- Submit requests for funding early.
- Plan well in advance so that required detail about the activity can be included with the request.
- Surplus funds may be less likely because some gifts are limited to underwriting uncovered costs.

The most important recommendation for this time of transition is that individuals requesting financial support check early with relevant companies regarding the company's current procedures.

Point of Care Learning Working Group Established

By Floyd Pennington, Ph.D.

A Point of Care Learning Working Group has been established to unify the broad spectrum of the social sciences driving advances related to point of care learning for healthcare professionals. The mission of the group is to improve the practice of healthcare providers by advocating for research related to point of care learning and to facilitate the review, exchange, and assimilation of findings from point of care learning research into practice of clinical medicine and continuing professional development. The group serves as a forum to encourage and facilitate research and for the periodic review, exchange, and assimilation of findings from research into practice of clinical medicine and continuing professional development. A key function of the Point of Care Learning Working Group is to articulate the evidence that supports effective point of care learning by healthcare providers. To achieve these purposes the group has established the following objectives:

- To review new data on point of care learning initiatives and its relevance to the professional development of healthcare professionals and the continuing education enterprise.
- To understand the theoretical and practical rationale for various approaches to point of care learning for healthcare professionals.
- To develop a consensus on practical guidelines for effective approaches to day-to-day point of care learning initiatives.
- To disseminate the results of the work of the Point of Care Learning Working Group widely throughout the continuum of healthcare education.
- To fund research with a high probability of impact on point of care learning.

The inaugural meeting of the group was held September 17-19, 2004 at the Inn at Eagles Landing in Stockbridge, Georgia. Twenty-one invited participants from the United States and Canada participated in a two-day discussion of issues and research related to point of care learning. The Chairman, Floyd Pennington, M.D., Associate Director of CME at the University of Florida College of Medicine and Chairman of the Board, PBLIC.org, facilitated the groups' discussion.

Don Moore, Ph.D. presented a historical look at point of care learning reminding the group that efforts related to encouraging physician learning at or near the point of care have deep roots in CME. Nancy Davis, Ph.D., from the American Academy of Family Physicians and Charles Willis, MBA of the American Medical Association shared the efforts of their respective organizations to encourage and acknowledge point of care learning for physicians. Researchers from several organizations shared their current investigations in graduate medical education and continuing medical education.

The group was challenged to define "point of care learning". A working definition was framed and is currently under review by the group. Small group discussions generated a number of suggestions for point of care research studies. The group established priorities for studies needed that will lead to a better understanding of point of care learning and what needs to be done in the larger context of professional development to support these efforts.

One study suggested by the group has since been funded. The Medical Association of Georgia has received a grant from Blue Cross Blue Shield of Georgia to conduct a project that will be evaluated using administrative data from the insurer.

Retracing our Roots - A Series of Interviews with SACME Founders and Leaders

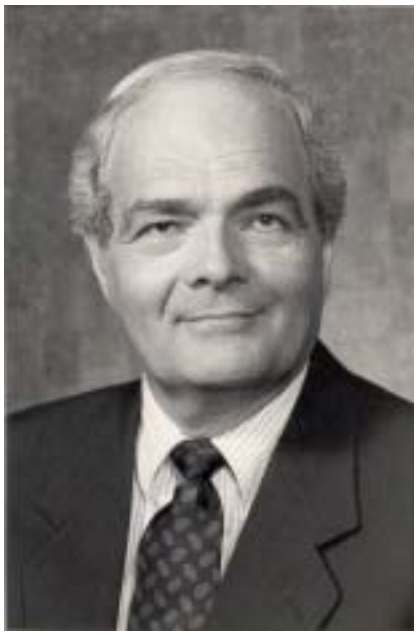
Dale Dauphinee, M.D., was President of the Society (then Society of Medical College Directors of CME) from 1988 to 1989. Continuing medical education (CME) has been but one portion of his extremely distinguished career that has spanned the entire continuum of medical education and leadership in academic medicine. He was interviewed in August 2004 by Barbara Barnes, M.D., M.S.

BB: How did you become involved in the Society?
DD: When I was Associate Dean for Medical Education at McGill, our CME Director, Guy Joran suddenly took ill and I was asked to "temporarily" assume responsibility for the program. When I attended my first SMCDCME meeting, I was surprised to learn that the next spring conference of the Society was scheduled to be conducted in Montreal. I therefore became quickly engaged in the organization. This was a particularly exciting time because, through the efforts of Dave Davis and others, the Montreal meeting was the first in which research (RICME sessions) was combined with the organization's business meeting. Out of these research efforts grew the change study. Although my direct involvement with CME at McGill lasted only for two years, I continued to be involved with the Society.

BB: What was different about the Society in those days?
DD: Because only the directors were involved, the Society was much more informal. The structure of the organization was very informal and most of the administrative work was performed by the president and his secretary. All of the documents were maintained in a briefcase that was passed from one president to the next. We were fortunate to have a number of individuals who had served in a variety of leadership roles and were well connected outside of our field. One example is George Smith who had been a dean and completed training in strategic planning. These leaders saw the "big picture" of CME and medical education and were able to articulate a vision of how the Society could help our field grow and develop through research and enhance a visibility.

BB: What were your major accomplishments as the president of the Society?
DD: My first goal was to "get beyond the briefcase". I recognized that we needed an infrastructure to assure administrative continuity and support the volunteers who serve in leadership roles. In addition, we needed to develop better communication strategies among the membership. Given my previous experience in other organizations, I recognized that building infrastructure requires a period of years and I worked closely with prior and subsequent presidents such as Dennis Wentz, Bob Cullen, Jim Leist, and George Smith to gradually establish processes and procedures, identify options for administrative support, and improve communication.

My more immediate goal was to make the Society more visible within the realm of academic medicine. We were accepted into the AAMC's Council of Academic Societies and were very fortunate at our first meeting to have a strong endorsement of CME by one of the awardees. In 1990 we were asked



Dale Dauphinee, M.D.

to serve on an AAMC committee addressing issues related to conflict of interest. To my knowledge, this was the first time the Society was invited to participate in the development of policy statements. This moved us from participation on the fringe to being a recognized stakeholder in shaping guidelines for academic medicine.[1]

BB: How has the Society changed?
DD: The expansion of membership beyond the directors has resulted in much greater diversity. It is very encouraging to see individuals such as Nancy Davis who have responsibility in specialty societies assuming leadership roles in SACME. We now have a much more formal and stable administrative structure accompanied by defined policies and procedures. In addition, the listserv has greatly enhanced communication among the membership.

[1] The work of this committee resulted in production of a monograph on guidelines for faculty relationships that remains one of the most comprehensive policy statements on this topic.

BB: What hasn't changed?
DD: CME still does not occupy a central position in the academic environment and it is difficult for individuals who are consumed with operational responsibilities to move into research and higher-level evaluation. It is surprising that CME has not become more closely integrated with performance improvement. I think we have made strides in addressing issues such as conflict of interest but further progress needs to be made.

BB: What effect did your leadership role in the Society have on your career?
DD: At the time of my SACME presidency, my career in education was coming to an end. As I transitioned into the role of department chair at McGill, the network of colleagues developed through participation in the Society, the Association of American Medical Colleges, and the Council of Academic Societies was integral to my career development. In particular, I became aware of the importance of lobbying and drew heavily on the resources of the AAMC's government relations department. I became aware that, although the Canadian health care delivery and medical education systems are very different than those in the U.S., there are many similar issues. I have met a number of terrific people through my various roles in the Society, many of whom have become friends for life.

BB: What impact does the Society have on Canadian members?
DD: In the 1960s and 1970s, a large group of colleagues returned to Canada following medical education training in Chicago, Michigan, and Buffalo. The Society became their "home away from home", providing a venue to present research findings and interact with friends from the U.S. and Canada. This was a major factor in supporting the career development of individuals such as Wayne Putnam, Jocelyn Lockyer and John Parboosingh. Participation in the Society has broadened our perspectives and has made us recognize that we deal with a number of universal issues such as improving the quality of primary care services and developing objective measurements for the processes and outcomes of care delivery.

BB: What is your vision for the Society?
DD: I hope that we can provide increasing support for our members' continuous professional development. I think we are working very hard to do that. Our organization is a good size: small enough that we feel comfortable calling on one another but large enough to have a major influence. I hope we can gradually begin to "close the loop" by linking educational interventions with definitive improvements in physician competency and clinical care.

News from the American Medical Association

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

"The innocent watch, an object for measuring motion, not time."

The narrator of Vladimir Nabokov's 1974 novel *Look at the Harlequins* captures the challenge for the AMA's Physician Directed Internet CME Pilot Project Steering Committee in developing final credit metric recommendations to govern this type of CME. On the one hand, time provides an unobtrusive mechanism for tracking physician use of these online clinical resources. And the duration of an activity at least signals a physician's commitment to the activity since, after all, time may be his or her scarcest commodity.

On the other hand, are we just "measuring motion" rather than what a physician might do with the clinical information he/she seeks? A didactic lecture may be an entirely passive experience depending on what the physician participant brings to the experience; however, does a new mode of CME challenge us to raise that standard, to better document a genuine learning experience for physicians?

Set against these concerns is the fact that these clinical databases have established their usefulness. Regardless of CME, thousands of physicians consult PubMed and similar databases every day, either as decision support tools at the point of care or later, when they can take a bit more time to search on relevant topics. We have to balance credit system requirements that should **encourage** use of a valuable educational tool, with an obligation to consider what (if anything) separates just using these databases from structured professional development.

Online point of care searches can also be tracked according to the topic reviewed, with a fixed increment of AMA PRA category 1 credit assigned for each search. This arrangement could disengage the clock from the credit metric, although the database managers would still have an interest in tracking aggregate use patterns, of which time is still one dimension.

Some of the steering committee's most spirited discussion has centered on whether or not physicians, in order to obtain additional credit, should be expected to review their inquiry, the sources checked, and the application to practice ("you found something; what did you do with it?"). The argument can be made that this already happens, in the patient record, but in the absence of a fully integrated system this remains difficult to document.

Some consensus emerged that additional credit was warranted for physicians who took the time to reflect on whether their topic reviews were applicable to practice (and how), so long as it could be done asynchronously and was not limited to point of care topic searches.

The steering committee has grappled at length with these issues and expects to be done soon. To some extent, the wind is at our backs. Demographics will answer one of our biggest concerns, barriers to adoption. Increasingly, young physicians in training and those entering practice will be unable to imagine a world that is not wireless and digital. These "digital native" physicians will not just rely on their PDAs, they will wonder why your system is so slow.

* * *

Breaking news: the AMA Council on Medical Education, at their September 17 meeting, approved the AMA PRA recommendations of the performance improvement pilot project. The content of the final language hews closely to what I described in my last column and should offer CME providers and physicians some exciting new ways to think about how they construct some of their professional development activities.

Performance improvement CME initiates practice based learning as part of the AMA PRA credit system, linking a data driven process (for CME) to how physicians assess their practice. We hope providers and physicians interested in implementing this form of CME apply it not only for disease management but also to systems issues (for example, patient safety).

We have begun work with the ACCME to assist them in developing accreditation guidelines for performance improvement activities. In addition, we will draft several case studies that detail how a provider can design a performance improvement activity. AMA PRA guidelines for performance improvement activities can be found at www.ama-assn.org/go/cme under "Provider Resources."

* * *

Finally, I have the pleasure of announcing the new Director of the AMA Division of Continuing Physician Professional Development. Alejandro Aparicio, M.D. joined us on September 1, after serving as Director of Medical Education and Associate Medical Director at Advocate Illinois Masonic Medical Center (Chicago), as well as Vice President for Medical Affairs at Ballard Health Care (Des Plaines, Illinois).

A certified internist and geriatrician, Dr. Aparicio has led both the Illinois Alliance for CME and the Illinois Geriatrics Society, is a Fellow of the American College of Physicians, and currently serves as Vice President of the Illinois Medical Directors Association. He has volunteered as a site surveyor for the ACCME and taught for a number of years at the University of Illinois at Chicago College of Medicine. Most recently Dr. Aparicio was appointed to the 2005 White House Conference on Aging.

Please join me in extending a warm welcome from the SACME community to Dr. Aparicio.

* * *

I look forward to seeing everyone at our fall meeting in Boston next month.

A SACME leadership retreat was held in Ottawa, Canada on August 30-31, 2004. In attendance were Craig Campbell, M.D., President, Nancy Davis, Ph.D., Past President, and Martin Hotvedt, Ph.D., President Elect. The retreat allows the leadership to brainstorm, set goals, and plan for future directions for the Society.

Membership News: SACME Welcomes New Members

The Society for Academic Continuing Medical Education is pleased to welcome a number of new members to this organization. The following members have been confirmed over the past year:

Julie A. Aikins, M.S.Ed., Manager, Educational Programs, American College of Surgeons, Chicago, Illinois

Lois Colburn, Executive Director, University of Nebraska Medical Center, Center for Continuing Education, Omaha, Nebraska

Lourdes C. Corman, M.D., Professor of Medicine, University of Alabama Birmingham; Chief Internal Medicine Division, Huntsville Regional Campus, Huntsville, Alabama

Jack Dolcourt, M.D., M.Ed., Medical Director for CME, Primary Children's Medical Center, Division of Neonatology-Department of Pediatrics, Salt Lake City, Utah

Todd Dorman, M.D., Associate Professor, Johns Hopkins School of Medicine, Baltimore, Maryland

Steve Hillson, M.D., M.S., Assistant Dean, University of Minnesota, Minneapolis, Minnesota

Ginny Jacobs, M.L.S., M.Ed., Operations Director, University of Minnesota, Minneapolis, Minnesota

Kathleen A. Johnson, Ed.M., Manager, National and Regional Skills Centers and Experiential Learning Programs, American College of Surgeons, Chicago, Illinois

Sonya R. Lawson, Ph.D., Assistant Professor - Continuing Medical Education, Virginia Commonwealth University, Office of Continuing Medical Education, Richmond, Virginia

Michael P. Lischke, Ed.D., M.P.H., Director, Northwest AHEC, Wake Forest University School of Medicine, Winston-Salem, North Carolina

Bernard A. Marlow, M.D., CCFP, FCFP, Director of CPD/CME, College of Family Physicians of Canada, Mississauga, Ontario, Canada

Patricia McNally, Ed.D., Assistant Dean, Educational Affairs; Assistant Director, CME, Loyola University of Chicago, Stritch School of Medicine, Maywood, Illinois

Greg P. McQueen, Ph.D., Senior Vice President for Academic Affairs, University of North Texas Health Science Center, Ft. Worth, Texas

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SACME Membership Statistics

The Society's Executive Secretariat is currently processing membership renewals for the 2004-2005 year. The following applications/renewals have been received.

7 Continuing Members
24 Emeritus Members
6 Honorary Members
159 Voting Members

Thus, the total 2004-2005 roster includes 196 members as of October 5, 2004. Thirty-eight membership renewals are still outstanding. The Secretariat urges all members who have not yet sent in dues payment for 2004-2005 to do so as soon as possible. If you are not sure that your payment has been sent, please check the web site's Members Only section to download a pdf directory or an Excel file listing the paid members of the Society. If you are not on that list, then your renewal has not been processed.

For any questions regarding membership, please contact the Executive Secretariat by phone at (205) 978-7990 or email sacme@primemanagement.net.

INTERCOM - TIME TO PASS THE BATON

By Joyce M. Fried

It seems unbelievable that I have been the editor of *Intercom* for almost four years. It has been my honor and my pleasure to serve the Society in this way and I pass the baton with relief and yet with a little sadness. I hope you have enjoyed reading the newsletter as much as I have enjoyed putting it together.

Many thanks are in order at this time. The Associate Editors of *Intercom,* Nancy Davis, Ph.D., Linda Gunzberger, Ph.D., Rosalie Lammle, John Parboosingh, M.D., David Pieper, Ph.D., and Melinda Steele, M.Ed. (and formerly Rosalind Lewy, M.Ed.), have been a real source of support, cheering me on, providing ideas for articles, and writing many of the pieces themselves.

It has been a delight to work with each of the Society presidents who served during my tenure as editor. I enjoyed this task so immensely that I have forgiven Paul Lambiase for roping me into it in the first place at the end of his term. Barbara Barnes, M.D., M.S., Jack Kues, Ph.D., Nancy Davis, Ph.D., and Craig Campbell, M.D. have all been wonderful writers and contributors and terrific cheerleaders. It has been inspiring to observe their outstanding leadership of our Society.

One could not ask for a better management team for the Society than Prime Management Services. Jim Ranieri made production of the newsletter the easiest part of the whole process. Never flustered, always timely and responsive, he was a pleasure to work with and I will truly miss this collaboration.

Finally, I would like to thank Ronnie Davidson, Ed.D. for agreeing to provide a grant from CMEinfo.com for each issue of *Intercom*, enabling publication of a paper copy of the newsletter. I continue to feel strongly that a paper copy is essential to maximizing the effectiveness of this newsletter.

It is indeed a pleasure to introduce the person to whom I will be passing the baton beginning with the February issue. Melinda Steele, M.Ed. has graciously agreed to assume this task as she steps down from her role as Chair of the Program Committee. Melinda is the Director of Continuing Medical Education at Texas Tech University Health Sciences Center School of Medicine in Lubbock, Texas. She received a Masters of Education degree in instructional technology and design from Texas Tech University, a Bachelor of Science degree in education from Hardin-Simmons University and an Associate Arts degree in Communications from Weatherford College. She has been active in CME since 1992. She is a tireless worker and I know that this newsletter will be in good hands.

Melinda Steele, M.Ed.

It has been gratifying to watch the Society grow and flourish and to be able to chronicle some of this in *Intercom*'s pages. I look forward to participating and contributing in other ways.

For up-to-date information
on SACME activities
visit us often at
http://www.sacme.org

INTERCOM

Newsletter of the Society for Academic
Continuing Medical Education
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Birmingham, AL 35216

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UPCOMING EVENTS

November 5-7, 2004
SACME Fall Meeting
Association of American Medical Colleges
Boston, Massachusetts
Contact: Jim Ranieri (205) 978-7990

November 18, 2004
1st Regional Conference on CME: New Directions in Physician Learning
Hoffman Estates, Illinois
Contact: Regina Littleton at the AMA (312) 464-4637

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

April 14-17, 2005
SACME Spring Meeting
Lake Travis, Texas
Contact: Jim Ranieri (205) 978-7990

June 25-30, 2005
Summer Research Institute
Halifax, Nova Scotia, Canada
Contact: Craig Campbell, M.D. (613) 730-6267

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