

THE KATRINA EFFECT ON TULANE CME: A PROFESSIONAL AND PERSONAL REFLECTION

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We have observed many catastrophic events in recent years – 9/11, SARS epidemic, numerous major hurricanes in the Atlantic and Gulf of Mexico, tornadic activity, wild fires, blizzards and ice storms, a tsunami, and the earthquake in Pakistan. All have resulted in levels of destruction and loss. This reflection depicts one story – the experience and effect that Hurricane Katrina had on the CME department of Tulane University Health Sciences Center and its staff.

Living and working in a hurricane-prone region of the U.S., as several CME providers do, you tend to begin *The Weather Channel* vigil on June

1st of each year. Furthermore, you dissuade any CME activity during the months of August and September without the sponsoring departments' full understanding of cancellation and financial risks that are potential with even the threat of a hurricane. Theoretically, 2005 was no different. We had two small, local activities planned during August and September then nothing else until mid-October, usually considered low-risk timing. The August activity was held the weekend before Katrina. The one in September would never happen as was the case with all of our Fall programming, exclusive of one small annual psychiatry activity that would eventually occur in mid-December.

When we left the office on Friday, August 26th, it was safely assumed that, at most, we would be out a couple of days. That was fine because we would still have plenty of time to proof and send our Reaccreditation Self Study Report to the ACCME well before the September 9th deadline. We had given the Self Study Report to our printer on Wednesday, August 24th. [Survey was scheduled for November 15th in New Orleans.] On Monday,

August 29th, Katrina changed every professional and personal aspect of our lives, not for a month or two, but for years to come.

Prior to the threat of any hurricane or tropical system, the administration of Tulane University diligently reminds all faculty and staff to monitor the university's emergency website or to regularly call the emergency 800 number. Realizing the potential of this storm and its northward track, administration shut down the servers and evacuated students unable to evacuate on their own. In days to follow Katrina's attack and devastation, the senior leadership of the health sciences center and university moved to Houston where Tulane's School of Medicine would be housed at Baylor University College of Medicine for the 2005-2006 academic year. Tulane administration reestablished the emergency website hosted on Baylor's website and began the arduous task of locating and communicating with faculty, staff, and students scattered around the country. Cell phones were useless; many

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FROM THE PRESIDENT

By Martyn Hotvedt, Ph.D.

As CME professionals, what is it that we are really about? Do we provide continuing medical education to physicians? Yes, probably. Do we help physicians continue to learn their profession? Yes, hopefully. Is CME making any difference in the practice of medicine? Are we, CME professionals, really helping physicians improve their practice of medicine? The debate goes on. Does elementary and secondary education make any difference for our children? Does a college education make any difference? The answer to all of these is “of course”. But can we improve any of these processes?

As this is my last column as President of SACME, I would like to extend a challenge to our membership. Several years ago I was directly involved in the development of a learning culture for a large hospital system focusing mainly on helping physicians improve their medical practice. One of the most important things we learned during this process was how multi-dimensional and complicated the learning process is within the context of medical practice. In 2003, I wrote an article in this newsletter describing the *Double Helix of Practice Based Learning and Improvement*. One of the conclusions we reached in our work was that individual physicians continue to learn on their own AND continue to learn through interactions of the various groups in which they participate. But these are not two unilateral processes of learning by oneself and by learning within the group context but rather these learnings are intertwined and reinforced through self-reflection and group reinforcement. As stated, this seems obvious to the reader. We all know individuals learn and continue to learn. We also know that individuals within groups and the groups themselves continue to learn. It seems obvious that these efforts would be intertwined and reinforced or react against one another. But to actually plan educational experiences, which build on both of these processes and the resulting collage, was a very exciting experience.

My challenge to the SACME membership is to recognize the double helix nature of what we are about and to develop research which will examine how we can help physicians maximize their learning and improvement. I believe

we are all aware of these dynamics and are individually adapting our programming to take these dynamics into consideration. I now believe it is extremely important for us to begin to share some of our “softer” approaches even

though many may not exactly fit our accreditation models. The complexities of our work do not easily lend themselves to linear descriptions, but if we are able to share our attempts at not only educating the individual physician, but also group education, then we will be making real progress. The truly messy part of the process is helping individuals reflect on group learning and helping the group incorporate the individual learning's of its members.

I do not expect that by next year we will have a manual to completely describe how to do this. Rather, I would be very pleased to see our work helping new members to SACME become sophisticated practitioners who are able to manage the complex and dynamic environments in which we work. This model applies to each of us as well as to the physicians that we try to help. It continues to be important for SACME to provide continued learning for all our individual members, and through our group we can help move the profession forward.

It has been an exciting year for me as President and I want to thank each of you for your support. In many ways, “the Golden Age” of CME is just ahead of us. We are becoming knowledgeable and sophisticated about CME and we are being recognized as important players in the continued improvement of medicine. We should be proud of what we have done and determined that we are going to continue in our efforts to help physicians learn and improve.



IMPROVING READABILITY, STYLE, AND ACCESS TO THE *JOURNAL OF CONTINUING EDUCATION IN THE HEALTH PROFESSIONS*

By Paul Mazmanian, Editor, JCEHP

The *Journal of Continuing Education in the Health Professions* (JCEHP) is a 64-page, peer reviewed quarterly publication looking for page space. Readers expect studies that link research to planning and the implementation of continuing education activities. Not only are tables, figures, and text important, but access to questionnaires, interview protocols, instructional material, and other tools of the trade often is essential to the success of our readers.

In 2006, the journal will look a little different. Readers will find more words to the page and the opportunity to access complementary material at JCEHP.com, the website controlled by JCEHP's owner organizations: the Alliance for Continuing Medical Education; the Council on CME, Association for Hospital Medical Education; and the Society for Academic CME. Joyce Fried, Director of Special Projects, at the University of California, Los

Angeles, is leading the effort with Jossey-Bass Publishers, to improve readability and style of the Journal. Laure Perrier, Information Specialist from the University of Toronto, and Web Editor of JCEHP.com, is working to enable on-line access to all twenty-five years of the Journal's issues.

Subscriptions to hospitals and medical libraries are growing and the number of manuscripts received from every corner of the world is increasing. JCEHP published authors from Argentina, the Central Asian Republics, France, Mexico, and Sri Lanka, during 2005. To respond to the broadening global interest, the editorial staff continues to explore better ways of using available page space and the emerging capacity of JCEHP.com, while the Administrative Board of the Journal revisits its business plan to assure ongoing editorial and financial success of these endeavors.

RICME RESTRUCTURING FOR BIENNIAL MEETINGS

Research in CME is an important element of SACME's identity. The "academic" in the title refers not only to the universities and medical colleges that we work in, but also to scholarly work and inquiry about CME. We are really proud that many of the leaders in CME research are members of SACME, and that the *Journal of Continuing Education in the Health Professions* is the foremost journal in this field. The Research in CME (RICME) session at our meetings is well attended and the evaluations are good. It can be fairly intimidating for a novice to follow seasoned researchers such as Jocelyn Lockyer to the podium, but presenters frequently comment that they find the environment very supportive and encouraging, and that they get very useful feedback on their projects.

Over the last few years, the research committee has noticed that abstract submission rates can be very variable, and that only those researchers with extremely active programs have enough material to present new material,

or even updates, twice a year. At the Research Committee meeting on November 4, held in the Omni Shoreham, we decided to change the RICME format, and to limit abstract submission to once a year. We decided to have Best Practice and Research peer reviewed presentations at the Spring meeting, as we have greater flexibility in that program's schedule, and it provides a more relaxed and intimate atmosphere. At the Fall meeting, held in conjunction with AAMC, RIME etc, we propose using the RICME timeframe to address topics of interest and keynote research projects, and will continue to run a research methods workshop.

I hope that this change in our programs further enhances your enjoyment of the meetings, and encourages both established and new researchers to share their insights on the practice of CME. If you have any comments to make about this change, please contact me: Gabrielle. Kane@rmp.uhn.on.ca.

SPRING 2006 MEETING HIGHLIGHTS: KEY WEST, FLORIDA - APRIL 5-9, 2006

The Program Committee has been busy planning the Spring meeting. The committee got a great start on planning in Washington during the Fall meeting.

Current issues in CME include how best to integrate what we know, what we do and how we do it in presenting effective CME activities designed to impact physician behavior and improve patient health. The Spring agenda is designed to discuss the importance of understanding these factors and integrating them so we as CME professionals can further our understanding and knowledge in managing and improving the CME we offer.

As in past years, all of Wednesday and much of Thursday will be dedicated to Society business including the Board meeting and committee meetings. The program has been structured to ensure that open committee meetings are scheduled during times when there is a likelihood of increased participation. Note the Research and Communications Committees are scheduled for Thursday afternoon respectively at 1:30 and 3:30. The Membership Committee is scheduled for Friday morning at 8:00 and the Program Committee is scheduled for Saturday morning at 7:45. The New Member Orientation will take place at 4:30 on Thursday followed by the opening reception from 6:00 – 8:00.

Thursday morning will provide an opportunity to interact with Robert Fox in a discussion of a data-driven approach to linking needs assessment, content development, and outcomes measures. The goal is to present both theoretical and practical aspects in the discussion, with recommendations for CME developers and funders. Friday starts off with a session moderated by Jack Kues on the use of technology as a means to integrate CME programming. Specifically, we will look at what possibilities learning management systems (LMS) offer in the development of on-line content, integrating content, and documenting and marketing a CME program, what the technology for LMS entails, and what the benefits are of implementing an LMS. On Saturday, Barbara Barnes will lead a session on the integration of quality improvement and CME to enable physician performance improvement.

Presenters will discuss both the need for synergy between quality improvement and CME and a practical approach for implementation.

Saturday continues with Nancy Davis moderating the Hot Topics session during which an update to the IIME Report will be presented. The Business Meeting lunch will follow. The remainder of Saturday is devoted to the Research in CME and Best Practices sessions, facilitated by Gabrielle Kane. RICME/Best Practices is always a great chance to learn from our peers as they present current research and innovations and seek feedback in a collegial environment. At the Town Hall meeting on Sunday morning, Lois Colburn will lead an informal discussion of how to meet the challenges of running a medical school based CME program. Issues include how to work within the rules, take risks that will improve overall quality, and maintain financial viability.

Registration and hotel information may be found on the SACME web site at <http://www.sacme.org>. Make your hotel reservations soon to take advantage of the conference rates. You may also want to consider booking your flights early to be sure to get the best flight times.

INTERCOM

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2005 FALL MEETING

The SACME Fall Meeting was held in conjunction with the 116th Annual Meeting of the American Association of Medical Colleges, November 4-9, 2005 in Washington, D.C. The meeting was well attended and the highlight was the discussion moderated by Chris Candler, MD, on virtual patient technology. Dr. Candler led a panel that included Grace Huang, MD; James McGee, MD; Carol Kamin, EdD; and Marc Triola, MD to discuss their successes and the future of using virtual patients in a variety of healthcare settings. Also well received was the presentation by Ronald Epstein, MD who discussed the value of a standardized patient program to medical education.



Chris Candler and Virtual Patient Technology Panel



Leadership and others participate in an experiment with the INTERCOM editor



All Business at the "Business Meeting"



Catching up with friends at the reception

MR. DAVIS GOES TO WASHINGTON: some personal reflections on information overload, knowledge management, and the AAMC Petersdorf Scholarship

By Dave Davis, M.D., CCFP, FCFP, FRCPC (hon); *AAMC Petersdorf Scholar-in-residence* (2005-06)

From late fall 2005 to mid- 2006, I'll be at the American Association of Medical Colleges as the Petersdorf Scholar-in-Residence. I feel fortunate to occupy this role and am grateful for the opportunity. At the very least, it affords me the opportunity to reflect on CME, physician practice and – most important – patient outcomes. This brief piece summarizes a few reflections on this opportunity. Sort of reflections on reflections, if you catch my drift.

It occurs to me that most of us – you as the readers, me the writer of this little piece - live in parallel universes. Whether we practice as health care providers, educators, administrators or whether we are patients and family members, we are deluged with mountains of *clinical* information. Mountains. There is an overwhelming body of evidence in the health care world, a pyramid of guidelines, monographs, original trials, break-through studies, systematic reviews: the list is endless. The amount of information is also overwhelming in the other aspect of our lives – the organization, administration, accreditation and evaluation of CME - the (you've heard this before) longest and arguably most important phase of a physician's or clinician's life.

But there is also a significant difference between the two worlds. In the clinical realm (where I live part time as a family physician), there are major systematic reviews of the primary literature, helpful guidelines, and even some systems of care in which just-in-time electronic reminders of best evidence help guide care. Each of

these can assist health professionals in digesting and adopting this mountain of information, closing the so-called clinical care gap. It's not perfect, but these aids are present and growing.

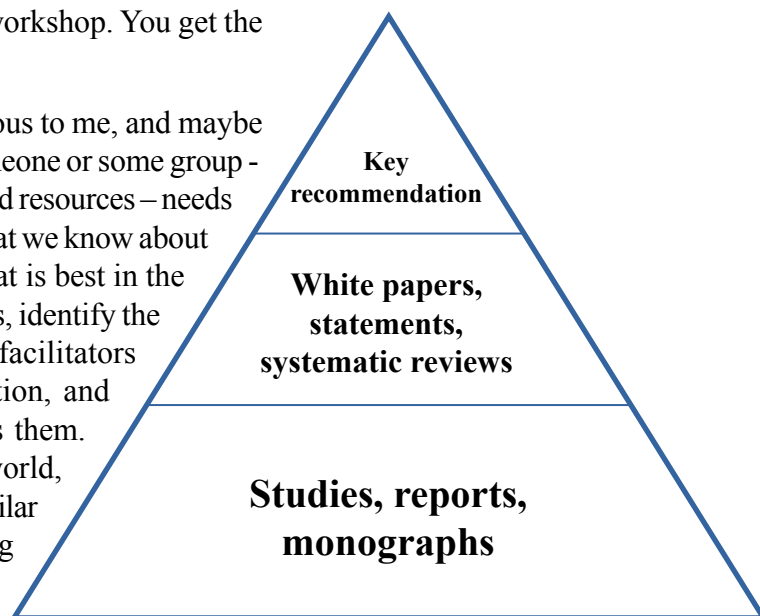
In CME however we have to deal with a (smaller than the clinical world but still significant) mountain of primary studies, handful of systematic reviews, and a plethora of task force reports, white papers, commissioned studies, strategic planning documents and other monographs and documents. And we make it worse: for reasons often less than scientific, we compound this problem by continuing to create further iterations of these white papers, studies, reports and high-level statements about CME. We seem married to the concept that the *report* will make the difference, rather than looking at the *tools or levers* for change. It strikes me that this process is akin to asking ourselves as CME providers, 'if we just tweak these learning objectives a little, maybe physicians will perform differently and our outcomes will be better'. Or maybe offering them a slightly longer workshop. You get the picture.

And so it's obvious to me, and maybe you too, that someone or some group - given the time and resources – needs to synthesize what we know about CME, distill what is best in the task force reports, identify the barriers to and facilitators of their application, and begin to address them. In the clinical world, this would be similar to extracting the key

recommendations from clinical practice guidelines, focusing on those with the best evidence, developing tools to help the quality improvement process, implementing of best practices, looking at *changing* the system, focusing on – most of all – what's best for patients.

And so, this is what my time as a Petersdorf Scholar will afford me – the opportunity to review and distill what we know about CME and its place in health care, maybe addressing the barriers to change. Maybe – most of all – bringing the patient care perspective to CME, forging a bridge between our parallel universes. Will it make a difference? I am not sure. Will it bring the two worlds together a bit? I hope so.

It is a great gift of time and resources, this scholarship, and I'm appreciative of the opportunity to pursue these questions. I'm also greatly interested in your opinions, thoughts and ideas. Feel free to write me at ddavis@aamc.org - or dave.davis@utoronto.ca.



RETRACING OUR ROOTS

Interview by Barbara Barnes

As president of SACME in 1990-1991, Jim Leist, Ed.D. was a strong advocate for collaboration among the professional associations in CME – a passion that continued during his presidency of the Alliance for CME. His background in leadership and business brought a unique perspective to SACME, forging a new direction for our organization.

BB: How did you become involved in the Society?

JL: The Society was the first professional organization in CME, beginning as an informal group of individuals who came together to discuss the future of the field. SMCDCME, as it was then known, became a formal association in 1976. The Associate Dean at Bowman Gray (now Wake Forest), who was a physician, could have been a charter member of the Society but we failed to respond to the initial invitation. We joined right after that. I was one of the few non-physicians in the organization in those early days.

BB: What were your major accomplishments as the president of the Society?

JL: I knew we needed to make changes in our profession. Everyone kept complaining about the lack of respect for the CME office within medical schools. I told our members that we had to be proactive and develop strategies to bring us on a par with other components of the medical education continuum. I was always inspired by Phil Manning's concept of practice-based learning and became convinced that the key to moving CME ahead was research. As past

president, I worked with Bill Nelligan to establish the research endowment, which was graciously funded by \$250,000 in unrestricted grants from industry. It was very heartening to see this fund grow so substantially under the tutelage of Paul Lambiase when he was treasurer.

I think I still have scars on my back from my efforts to create closer collaboration between the Society and other CME organizations. We had a unique opportunity in the early 1990's – Dave Davis was president of the Alliance and then became president of SACME and I held the same positions in reverse order. Both of us had a vision to unify the various professional organizations. We were successful in creating the partnership to oversee JCEHP, which also included AHME. However, the Alliance and SACME remained separate organizations.

I also tried to develop the younger members of the Society. When I was in the Army, I was befriended by a colonel who had a very positive influence on me. When I left for Viet Nam, I expressed my appreciation to this gentleman for his kindness saying "that I could never pay him back for what he did for me." He told me that the best way to thank him was to "pass it on". I never forgot his message. When I was in the leadership track I tried to be a mentor for a number of individuals, many of whom subsequently went on to serve in key positions of the Society.

BB: How has the Society changed?

JL: The Society now has a very strong emphasis on research, as exemplified

by projects funded by the endowment, RICME sessions, and increasing quality of articles in JCEHP, thanks to the leadership of Bob Fox and Paul Mazmanian. We have also broadened our membership to include individuals with academic interests who work outside of medical schools. I think this change will be very positive in terms of applied research, since many schools lack a close relationship with a clinical delivery system.

In old days, the AAMC provided administrative support to the Society, fostering relationships with their various committees and leaders. Brownie Anderson was an advocate for CME and facilitated our presence within the AAMC. In particular, the Society's entry the Council of Academic Societies helped to move us toward a more central role in academic medicine, rather than our traditional position as "marginal dwellers".

BB: What effect has the Society had on your career?

JL: When I joined, I got to know the great leaders in the field who became my mentors and counselors. In those days we didn't have a list serve so it was more important to build relationships with respected colleagues who would make themselves available to answer questions and offer advice. I feel truly privileged to have had the opportunity to interact with experts such as Phil Manning, Bob Richards, Bob Kristofco and many others who shaped my concept of CME and helped me define a strategic direction for the Society. I believe the best thing about our profession are the people that work in CME.

BB: What is your vision for the Society?

JL: I hope we can continue to move CME into a more central role within the continuum of medical education. We have done groundbreaking work, such as the change study. Although we are often not explicitly credited with these contributions, they have significantly shaped education across the continuum. We need to focus on developing learning interventions that really make a difference. I hope we can use the results of research

to enhance learning in practice, not only for practicing physicians but also for residents.

I remain hopeful that we can form stronger relationships with the Alliance and AHME. There are so many issues that are common to all CME providers, regardless of the setting in which they work. We need to understand how to optimize our resources and our energy to advance the field and provide benefits to the physicians, their healthcare teams and the patients that they serve.

NEWS FROM THE AMERICAN MEDICAL ASSOCIATION

By Alejandro Aparicio, M.D., FACP

In November 2005, the Council on Medical Education of the AMA approved a revision of the Physician's Recognition Award Booklet which will be known as the 2006 version. It is expected that the printed copy of the new version will be available in late January and, as with previous versions, it will also be made available on our web site.

With this version we return to one booklet format that combines what had been two separate booklets in the last version: one for physicians and one for providers. The new version includes changes that have taken place since the last version and that have already been communicated to physicians and providers. But other refinements of PRA policies were incorporated as well. We are confident that providers will start making any necessary changes, to be in compliance with the new PRA policies, as soon as the new booklet is received. However, we also understand that planning processes often start months before a CME activity takes place so we will not be monitoring for compliance until July 1, 2006.

Certain elements of the AMA PRA credit system were modified to better align with existing ACCME requirements. In other cases, changes acknowledge that certain provider requirements are logically met through compliance with the ACCME accreditation process. Following are highlights of some of the more significant changes in the PRA booklet and the rationale for those changes:

- The AMA has asserted trademark protection for its intellectual property by requiring *AMA PRA Category 1 Credit™* as the proper format whenever the complete phrase is used, such as in the Designation Statement.

- The Designation Statement has undergone a revision to make the wording more consistent with the migration from hours to credit:

The [name of accredited provider] designates this educational activity for a maximum of [number of credits] *AMA PRA Category 1 Credit(s)™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

- International physicians are now automatically eligible for *AMA PRA Category 1 Credit™*, without a provider application process, eliminating the "U.S. licensed" requirement from the AMA PRA credit system. This change simplifies the process for providers and recognizes the growing value of *AMA PRA Category 1 Credit™* in other countries, as well as international graduates in the United States not yet licensed.



- Accredited providers may now award *AMA PRA Category 1 Credit™* to faculty that teach at their designated live activities for the learning that takes place in the preparation phase. Two credits may be awarded for every hour of teaching. Since this type of learning was approved for Category 1 credit by the Council in 2000, physicians have only been able to obtain this credit directly from the AMA. Providers know their faculty and already maintain the necessary documentation, therefore the AMA decided to eliminate the need for faculty to apply directly to the AMA to receive the CME credits.
- Physicians may claim each year of successfully completed ACGME training for **either** endorsement toward a one year of an AMA PRA certificate (up to three years) **or** for a credit certificate for twenty (20) *AMA PRA Category 1 Credit(s)™*. The option of a credit certificate will help residents and fellows training in licensing jurisdictions that do not accept the AMA PRA certificate in lieu of CME requirements. Both options are only available directly from the AMA.

For questions and to learn more e-mail Charles Willis, MBA, Director of AMA PRA Standards, at charles.willis@ama-assn.org. Individual copies of the AMA PRA information booklet (2006 revision) are available upon request, with bulk rates for larger orders, pra@ama-assn.org; the full text can be printed off the AMA website at www.ama-assn.org/go/cppd.

With the rapid pace of change in the CME world, the next revision may take place earlier than would be expected based on the history of the booklet. We encourage all of you to contact us with comments on the changes, be it issues, disagreement or agreement with them, as well

as suggestions for further improvements. All of your comments will help and assist us in guiding the next revision as they helped and guided us in this current one.

On a separate topic, the 16th Annual Conference of the National Task Force on CME Provider/Industry Collaboration, was held October 24th-26th in Baltimore with a record registration of more than 600 participants. The title of this year's conference was "Practical Strategies for Survival in the Guideline-rich CME Environment of 2005."

Speakers focused on overall trends and perceptions of CME and on collaboration, while breakouts and case study sessions helped learners focus specifically on practical topics, including guidelines and how they apply to CME, resolving conflicts of interest, and successful examples of outcomes measurement. As always, the conference also provided a valuable networking opportunity to diverse stakeholders, including academic medical centers, specialty societies, medical education and communication companies, government and accreditation agencies, and the pharmaceutical and device industry. SACME members were well represented among presenters and participants.

To view presentations from this year's conference, or to stay up to date on plans for next year's conference, please visit www.ama-assn.org/go/cmetaskforce. We hope that you will join us in Baltimore, for the 17th Annual Conference, to be held October 16-18, 2006.

But before then, we look forward to seeing all of you in Key West.

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

towers were damaged or destroyed. Television and radio towers were knocked out, and studios were damaged and/or flooded. Except for the national coverage, information of a more local nature was difficult to obtain.

As the enormity of Katrina's wrath and of the levee breaches was revealed, it became apparent that we were not returning to our offices, and in many cases our homes, anytime soon. Accepting this reality, I called the ACCME and explained that our Self Study Report would be late by, being eternally optimistic, maybe a week or two! As the situation continued to unfold, David Baldwin contacted me with an unlimited extension, and Murray Kopelow graciously offered to share his home with any New Orleans family in need. Michael Fordis and Melinda Steele offered CME help in any way they could for which we were sincerely grateful. Jan Temple offered sage advice from her experience with Hugo which I heeded.

By mid-September and still at my mother's in Tennessee, I was finally able to find and talk with my fellow staff members. We were all safe and with family or friends. Tulane CME is a staff of seven (5.5 FTE). Four of us were fortunate with minimal damage mainly from wind while the other three sustained extensive damage from wind, rain, and flooding or, in the case of one, lost everything. We continued to stay in touch, and at the end of September five of us gathered on the northwest shore of Lake Pontchartrain in Hammond, Louisiana. From that point on, we were able to function from our homes as a CME virtual office. My office consisted of my laptop, cell phone, and a three-subject spiral notebook. We met every two weeks in various locations and in between our gatherings communicated with each other about joint-sponsored activities and how to proceed with Tulane-sponsored Spring activities. We also developed new programming in the Alexandria area. By staying in contact with the health sciences administration in Houston and as the Tulane database built on the Baylor website, we were eventually able to reconnect with faculty to discuss the future of CME activity. Many of the faculty refused to let Katrina interfere with their CME efforts. Most of the Spring 2006 activities will be held but on a smaller scale,

and a few of the Fall activities have been rescheduled for Spring 2006.

As the faculty began to return, they were fulfilling their clinical responsibilities at Tulane-Lakeside Hospital but missed the academics. In October, a Pediatrics faculty member initiated a multi-disciplinary Grand Rounds at Tulane-Lakeside to regain their collegial interaction and discussions. A different department or section assumes responsibility for each week and develops a topic or case of interest across disciplines. Our CME Grand Rounds liaison from the Pediatrics Department has volunteered to assume that oversight role and to make arrangements

We have a few joint sponsors with whom we have had relationships for several years. They also rallied to our needs. The Pediatric Academic Societies (PAS) in the Houston area offered housing and office space for as long as needed. Without access to our offices – files, forms, documents, and anything else that defines us as a CME department, PAS and the other joint sponsors were valuable resources for everything we had recently given to them. We were able to maintain constant communication with all and, in some instances, meet with them.

Another great source of information and forms was our Self Study Report. When we evacuated, I took a hard copy of the narrative in addition to a copy on my USB. Our department administrator had a hard copy and the CD-Rom that was to be sent to the ACCME, and our printer, we discovered later, took the original when she evacuated.

We returned to our offices on November 29th as part of the university's phased re-entry plan. In retrospect, we operated very creatively during those three months, much of which is credited to all our professional friends who offered assistance. Since our return, our time has been consumed with catching up and preparing files to send to the ACCME by January 6th. We are thrilled to finally be back in our offices, but the past month has presented a couple of challenges. We have limited access to the building (8 am – 4:30 pm) for energy and security reasons, in addition to losing two of our CME staff members in the November 1st university-wide personnel cuts. One of many casualties of Katrina has been the devastating

economic impact on the region. Tulane was not excluded from the impact and has experienced severe staff and faculty cuts as part of a university restructuring. Losing two staff members, Jane and Beth, with whom we had worked for many years, was very difficult on all of us. However, Jane has recently accepted a part-time position with the ACC and will continue to be able to work from her New Orleans home. Beth has volunteered to help us when her home is restored and they return from California.

“Hugs, not handshakes” was the headline of a recent feature article in the New Orleans’ Times-Picayune which discussed the new, post-Katrina (post-K) professional greeting. Nothing has ever been so true or therapeutic. Even four months later, the first post-K encounter with a colleague is not a handshake or “hello” but rather a reassuring hug and “how did you fare?” It has become part of the grieving and healing process.

In the last couple of months, the CME departments from LSU, Ochsner, and Tulane have met to discuss our cooperative Internal Medicine Board Review. At the first meeting we greeted each other with hugs, then our conversation was devoted to individual Katrina experiences, losses and offers to help those among us who lost so much. During the second meeting, we decided that, due to the unusual, post-K circumstances, the three institutions would share the hosting responsibilities for 2006 instead of one institution taking full responsibility.

Personal Reflection

My husband and I are among the minority who were spared the wrath of Katrina. It has been a life-altering experience that I trust will make us all stronger and better. We realize that we live a life of conveniences that can be taken away overnight, that we need to exhibit tremendous patience, and that we find it difficult to complain about anything when so many have nothing. During the three

months we were both working from home, we volunteered (as many did) in a relief center in the Episcopal Church we attend in Slidell. The stories of those who came to seek help were both heart-warming and humbling, yet sad. Many had lost their homes, loved ones, and family memories, but they considered themselves fortunate. The Times-Picayune has chronicled many individual losses in a daily feature entitled “Katrina’s Lives Lost.” Each day presents a touching story of a family member who died during or in the aftermath of Katrina and how the families are coping. I feel that it is our responsibility to share these losses with them.

There are signs of recovery and normalcy in some areas, but the mountains of debris, both natural and household, the lack of people, and driving daily through areas that have not changed since August 29th are constant reminders that it will take years to rebuild. The outpouring of generosity and support from groups and individuals around the country and the world continues to be astounding and is a testament to the human spirit. The following websites offer an opportunity to observe the rebuilding of New Orleans and the region – www.tulane.edu, <http://chronicle.com>, www.nola.com, www.neworleanscvb.com and www.nomenu.com. There are books already available about Katrina, but there are still many stories to be told and books yet to be written. Among them will be ones about the doctors who stayed in Tulane University Hospital and Clinic and their experiences both during Katrina and in the aftermath that followed.

The staff of Tulane CME wishes everyone a very safe and happy new year in 2006 and a year free of hurricanes and other catastrophes! Many thanks again for the thoughts, concerns, support, and offers of assistance from our friends in the CME community.

Program, abstract submission, hotel and registration information for the 2006 Spring meeting in Key West is now available on the web site: www.sacme.org

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UPCOMING EVENTS

October 16 - 18, 2006
17th Annual Conference of the
National Task Force on
CME Provider/Industry Collaboration
Baltimore, Maryland
Website: www.ama-assn.org/ama/go/cmetaskforce

April 5-9, 2006
SACME Spring Meeting
Wyndham Casa Marina Resort
Key West, Florida
Website: www.sacme.org
Contact: Deb Sutherland (813) 974-4953

October 27-29, 2006
SACME Fall Meeting
in conjunction with
AMMC Annual Meeting
October 27 - November 1, 2006
Washington State Convention & Trade Center
Seattle, Washington
Contact: Jim Ranieri (205) 978-7990