INTERCOM

*Official Newsletter of the Society of Medical College Directors of Continuing Medical Education*

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# CONSENSUS ON FALL MEETING: STIMULATING AND PRODUCTIVE

WITH THE TIMELY THEME, "New Horizons in CME," the annual Fall Meeting held in San Francisco, Oct. 20-22, 1990, featured an excellent program designed by the program committee, chaired by Robert Fore. Members were kept busy with committee activities, social events, and numerous opportunities to explore several new horizons.

Social activities included informal corridor consultations, a reception for new members, a Past Presidents' breakfast, and a luncheon for committee chairmen hosted by the Executive Committee.

At least eleven committees and special interest groups spent productive hours in the kind of work that is essential for organizational vitality and leadership. Finding whatever time they could in a tightly packed meeting schedule, the Executive Committee seemed to be in marathon session in order to complete the urgent agenda of the Society. On Sunday afternoon, an efficiently run general business meeting brought everyone up to date on many issues, including the list of new members (see page 7.)

Proposed amendments to the Bylaws were approved, eliminating the office of President-elect and substituting two new offices: First and Second Vice-president.

Members of the Nominating Committee were elected as follows:

Midwestern: Marge Adey
Northeastern: Ruth Glotzer
Southern: Sam Nixon
Western: Brian O'Toole

Learning activities explored new horizons. There was a generous exposure to the theory and practice of problem-based learning (PBL) as it might apply to CME. Centerpiece of the Saturday plenary session was a presentation, ably planned and efficiently led by David Davis on "Incorporating Problem-Based Learning Strategies into CME Programs." Dave was careful to define PBL for CME as a strategy that "employs any learning resource and employs a clinical problem as its major locus."

The audience participated in lively discussion of three well-prepared cases depicting critical issues in the planning of problem-based CME. Subsequently, a panel fielded questions and enjoyed a spirited discussion on the subject. The panelists were Bob Fox (Oklahoma), Marty Kantrowitz (New Mexico), Jim Leist (Bowman Gray), and Harold Paul (Rush).

The consensus was that: (1) active learning is better than passive learning; (2) PBL formats may dictate a decrease in the size of the learner audience and, therefore, will have cost implications, and (3) we need to study and learn more about adult learning behavior.

The plenary session also included a report by Van Harrison who succinctly summarized salient statistics of the biennial survey of Society members. Two trends of interest: (1) 60% of CME directors are not physicians, and (2) physician CME directors as a group are older than non-physician directors. The survey instrument continues to refine information-gathering-and-reporting formats. As it matures, it will be an even more important tool for use by members.

Other presentations were a report by Tom Meyer on focused/remedial CME, and a challenging discussion by Paul Mazmanian who demonstrated how research-based theory can be translated into program improvement.

Explorations of new horizons continued Sunday morning with three miniworkshops: "Using Chart-Stimulated Recall" (Jocelyn Lockyer and John Parboosingh, Calgary), "Issues in Joint Sponsorship" (Grace Wagner, Florida), and "Industry/Academic Relations" (Ruth Glotzer, Tufts).

The theme of problem-based learning in CME was continued on Monday evening in a program session scheduled jointly with the Group on Educational Affairs (GEA) of the Association of American Medical Colleges. Marty Kantrowitz and Dave Davis were joined by Howard Barrows, Associate Dean and Chairman, Medical Education Department at Southern Illinois University; and Jacques E. Des Marchais, Vice Dean for Academic Affairs at the University of Sherbrooke. Barrows suggested that PBL has merit because it contextualizes learning in a true problem-solving process. Des Marchais presented two scenarios that represented issues involved in situating PBL in CME and suggested some formats in which the strategy might work. Davis reviewed three studies in the CME research literature and indicated that they gave encouragement to planners to continue to develop appropriate models. Kantrowitz gave a general setting of the issues and key questions related to PBL throughout the curriculum.

Seasoned observers of the Society seemed to agree that this was a landmark meeting. It was characterized by excellence, high morale and impressive output.

**—Harold A. Paul, Editor**

# President's Comments

OUR HERITAGE AND OUR FUTURE. The Society is facing several important issues as we enter 1991. They all revolve around the ability of the Society to continue our heritage as a progressive society providing leadership in CME. These issues will challenge our leadership during the year, so they will need the attention of us all.

**Historian.** I am very pleased to announce that Dick Caplan, Society President in 1981, has agreed to work on the development of a history of the Society. Over the next two or three years, Dick will prepare a historical look at our organization's key issues and people of the past. His wit, insightfulness and writing skill should provide an enriching look at our heritage in both a comprehensive and abridged version.

**Awards Committee.** I'm also pleased to announce that an Awards Committee has been established to identify criteria and types of awards to be given annually by the Society for recognition of outstanding achievement in CME. The committee will be chaired by "Dutch" Reinschmidt and will include Marjorie Bowman, Phil Manning, Wayne Putnam and Dennis Wentz. If you have any thoughts about this committee's activities, please call Dutch or any of the other members.

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Wayne Putnam, Computer Corner
Richard Bakemeier, Education
James Leist and Robert Fore: Management, Leadership and Organization Development
Jocelyn Lockyer, Research Notebook

**Development and Endowment Committee.** The Executive Committee has concluded there is a need for the Development and Endowment Committee to provide continuing funds for CME Research, Education, Administration/Management and Service. In fact, it will be a re-formation of a committee established by Dennis Wentz during his presidency in 1987. By spring, I hope to have reconstituted that Committee with a new charge contingent somewhat on our plans for incorporation. This committee will be a key one for the Society's 1990 activities and for our ability to continue leadership in CME.

**Incorporation.** The Executive Committee has agreed to explore incorporation of the Society as a not-for-profit corporation. We will examine the pros and cons of this issue with the goal of bringing a proposal to the membership at our Spring Meeting in Toronto.

**CME National Leadership.** In San Francisco at the AAMC meeting, leaders of our Society, ACME and AHME (Tri-Group) met, as they have been doing semi-annually for the past three years. Dave Davis, a Society member who is President-elect of ACME, proposed a permanency of that group as the leadership for CME in North America. The prospect of a permanent "Joint Liaison Committee," maintaining organizational autonomy but sharing a common voice, was thought to be an idea whose time has come. Dave was asked to draft his ideas in more complete form for review and discussion at the next Tri-Group Meeting.

As this concept begins to become more clear, the draft proposal will be shared with our Executive Committee and membership. This idea should be a major discussion item on our Spring agenda.

**Editorship — Journal of Continuing Education in the Health Professions. (JCEHP).** Malcolm Watts has indicated that he wishes to give up the editorship of the JCEHP by the end of 1991. Working with our colleagues in ACME and in consultation with AHME leadership, we are methodically moving forward to identify a candidate to succeed him. A Search Committee will be appointed to begin screening candidates. It is my hope that the committee will recommend a candidate by early spring, with final selection planned by June 30, 1991. The new Editor would then have a six-month and two-edition transition with Dr. Watts.

Please check your institution, area hospitals, and other health science libraries (especially nursing and pharmacy) to see if they carry a Journal subscription. If not, encourage them to subscribe to this significantly growing peer-reviewed journal. In addition, consider preparing an article for submission to the Journal yourself.

James C. Leist

# BOOK REVIEW

**By Terrill A. Mast**
**Southern Illinois University**

*Strategies for Maintaining Professional Competence: A Manual for Professional Associations and Faculties.* Compiled and edited by Barbara Sanford. Canadian Scholars Press, Toronto, 1989. $18.50

This book contains the proceedings of a conference, but with a twist. "Strategies for Maintaining Professional Competence: An Interdisciplinary Conference" was sponsored by the School of Continuing Studies, University of Toronto, and took place on October 20-22, 1988. It was organized by Jacqueline Wolf of the School of Continuing Studies, Colin Woolf, then a member of the Faculty of Medicine (now an Emeritus Member of SMCDCME), and an interdisciplinary (all Canadian) Advisory Committee. The twist is that Sanford's book is a synthesis of what occurred and was decided at the conference, rather than being the usual collection of invited plenary presentations.

The book has a very logical organization, suitable to its intended function as a manual for faculties and associations. After introducing the need for professions to develop means for maintaining the competence of their professionals, it proceeds to address the various stages of professional development. At each stage the conference's focus on change is abundantly evident.

Chapter Two deals with how professional competence is presently defined and measured, and the influence of definitions on conceptions of maintaining competence. It suggests ways of improving the definition and measurement of competence, expanding the current emphasis on technical knowledge to encompass communication skills and self-directed learning skills. It argues for defining the "high risk" categories of practice, such as geographic isolation and aging. Then obstacles preventing change are examined, followed by ways to overcome obstacles and implement change strategies.

Chapter Three takes a similar approach at the stage of professional training. Here the conference recommends changes in professional training. Here the conference recommends changes in professional education to produce reflective practitioners, a la Donald Schon, author of *The Reflective Practitioner: How Professionals Think in Action.*

More interaction between faculty and students, and stronger links with researchers, practitioners and the community are recommended, as is telling students about the means and opportunities for continuing education in their profession. Again, the chapter examines obstacles to change, ways to overcome them, and implementing changes during professional training to improve the maintenance of competence later.

Chapter Three follows a parallel approach at the stage of the early years of establishing professional practice. Here orientation, mentors, counseling or advising services, and continuing education are important. Professional associations are encouraged to understand and address the special needs of beginning professionals.

The next chapter on established professionals stresses that self-assessment and contemporary communication technologies need to supplement, if not supplant, traditional continuing education formats, and that special attention needs to be given to geographically or organizationally isolated practitioners. Among the book's most controversial recommendations are that professions need to develop "standards of practice" and practice inspection systems. In a chapter entitled "Easing the Transition," the special issues regarding senior professionals are addressed.

Chapter Seven describes the current systems for administering competence in each profession: that is, the systems for licensing and entry into practice, regulation, disciplinary action, continuing education and re-certification. Changes in the roles of the public, professional faculties, statutory bodies, professional associations and government are discussed, as are the ways the modified systems should be funded.

This style of reporting a conference has strengths and weaknesses. I found it valuable to see the outline for the conference, the annotated list of pre-conference reading materials, the speakers list, and even the questions put to the working groups. However, the abridgement of what actually occurred is necessarily choppy, changing subjects as often as working-group conversations changed direction. Also, I was left wanting to read the more completely and carefully developed arguments of the plenary papers. And, insightful though the recommendations are, only so much can be accomplished in three days of conference. The book can only sketch strategies, so it falls somewhat short of being the "manual" promised by the subtitle. But leaving the reader hungry for more is perhaps a strength rather than a weakness.

A final word. The interdisciplinary nature of the conference provides some refreshing perspectives for those of us who usually think solely about the medical profession.

### Another Associate Editor Named

New member Richard Bakemeier, University of Colorado, is already actively involved in Society activity. His name has been added to the Publications Committee and the Special Interest Group on Education. He will serve *Intercom* as Associate Editor for Education.

### Call for Bids: 1993 Spring Meeting

Members are invited to submit invitations to the Executive Committee for hosting the 1993 Spring Meeting of the Society. Bids in the form of a letter should be submitted to the President prior to the Spring Meeting (1991) in Toronto, when the membership will then select the 1993 meeting site.

## ON QUARTERBACKS AND ELEPHANTS

*Some Thoughts on Leadership*

**By Robert C. Fore**
**Mercer University School of Medicine**

I've been thinking a lot about quarterbacks lately. My beloved University of Georgia Bulldawgs haven't had one during the 1990 season, and when you're known as Dr. Dawg, you have to be concerned. This looks like our first losing season in about 14 years. My cousin, Bubba Ray, has threatened to go up into the North Georgia mountains and live with his friend, Toole Shedd, and his mule, Phoole, until we win another Southeastern Conference Championship. Don't pray for Bubba Ray, pray for Phoole. But let's get back to the subject of quarterbacks.

We frequently hear football analogies used in the world of business, government, and education. In the Continuing Medical Education Stadium, how often have you had to drop back and "punt" or "lateral" only to have someone "fumble"? Have you broken out in a cold sweat when you looked at the clock and saw the "2-minute warning" or have you felt you were the victim of "unsportsmanlike conduct"? You see, each of us is a quarterback with responsibility for "moving the team."

The quarterback is expected to lead and to serve at the same time. Does this sound familiar? He is expected to motivate his players and execute the game plan. If one of his players misses his assignment, the quarterback is still expected to gain yardage on his own. In victory, the quarterback rarely receives all the credit, but in defeat, he usually receives most of the blame. Someone with more authority and power recruits the players he has to win with. One wonders why anyone would want to assume the role of a quarterback.

How can we be effective quarterbacks in our medical schools, and how can our Society be a quarterback in the stadium of medical education? We all have opinions about what it takes to be an effective leader. The first goal in the Strategic Plan of our Society relates to leadership. President Jim Leist has established leadership as his top priority. The Program Planning Committee views leadership as the central theme for our spring meeting. It is apparent that leadership is the key for our survival as a Society and as individual professionals.

So what must every leader possess to be effective? It's called vision. Vision makes the difference between short-term thinking and long-range change. In *Teaching the Elephant to Dance*, James Belasco describes how trainers teach young elephants to stay in place by shackling them to stakes in the ground. Later on, they can keep adult elephants in place by simply putting a small metal bracelet on one leg and attaching it to . . . nothing.

Organizations are like elephants. What is the organizational equivalent to the elephant's bracelet? "We've always done it this way." If a quarterback has no vision to see the field and the complexities of the defense, he will fail. Sure, the first down is important, but the vision of the victory and the championship is what empowers the whole team. Vision teaches the elephant to dance.

Will you share your vision of continuing medical education through your Society participation? Will you improve your quarterbacking skills through service on one of our committees? I think we're about to score a winning touchdown. Now if I can only get Bubba Ray off that mountain. Anybody have some fried chicken?

BIBLIOGRAPHY

Belasco, James A. *Teaching the Elephant to Dance*, Crown Publishers, Inc., New York, 1990, 276p.

## Computer Corner

**By Germain Houle, Director**
**Centre for Continuing Medical Education**
**McGill University**

End-user searching of the medical literature is an idea whose time has come. Increasing numbers of physicians use a variety of systems to enhance their access to information that will assist them in clinical decision-making. Directors of continuing medical education should recognize the potential to include in their courses opportunities for practicing physicians to learn the skills necessary to successfully use these new software packages and search systems. There are many on the market, and I do not pretend to have done a thorough review. However, I am personally enthusiastic about Grateful Med, created by the National Library of Medicine to simplify the process of searching the NLM's Medical Literature Analysis and Retrieval System (MEDLARS).

I have found Grateful Med to be the easiest and friendliest "front-end" software available today. It has been improved and revised, and is now available as Version 5.0. Grateful Med has condensed the literature search into four steps: (1) It helps to formulate the search, which is done off-line and therefore the "meter is not running," (2) It calls the NLM's computer in Bethesda, Maryland, (3) It runs the search and disconnects, (4) It displays the search results and, if you wish, will print them (including abstracts) or down-load them in a file on your own computer. You can then print the results at a later date. An important feature of this service is that some 60% of the citations contain abstracts. This can be useful in providing essential information without having to look up the original.

The search can be done by Author, Title of Article, or Subject. Searches on subject terms are aided by a "built-in" Medical Subject Heading (MeSH) index. When you enter your subject, one keystroke will bring up the relevant MeSH headings alphabetically, from which you can select the most appropriate keyword. This feature is of tremendous help in speeding up your search, keeping the search limited to relevant articles and saving money in connection time. Another useful feature for most practicing physicians is the ability to readily limit retrieval to review articles (to avoid primary research studies) in the English language.

I would strongly urge any CME Director not yet familiar with end-user searching to acquire Grateful Med and experience it for yourself. You won't regret it!

# RESEARCH NOTEBOOK*

## AN EVALUATION TECHNIQUE WORTH CONSIDERING: THE FOCUS GROUP

The focus group is a very powerful technique which can be appropriately used in CME as a research tool to assess needs or to evaluate an educational product. The process involves the careful selection of individuals representing a large audience whose opinion you wish to sample. Each person should represent a subset of the group from which you wish more information. Unlike many group techniques, the main purpose here is not to reach consensus. If the individuals represent different groups with differing views, then knowing these differences and determining their depth and cause is more critical than reaching consensus. Each person must be made to believe that the opinion of his/her group is important.

While random selection is sometimes used, you may miss an opportunity for relationship building. When done properly, approaching an individual with the premise that you respect his/her opinion and want help usually results in that person agreeing to cooperate. Just as with any group process, group size may vary, but no more than ten persons usually works best. To obtain a broader opinion more groups may be used.

The group is asked to focus on a particular question or set of questions. The goal is to probe the question in detail. This is a qualitative, not quantitative, technique. Unlike the questionnaire, you are able to use follow-up questions and ask the all important why? how? tell me more, etc. While a survey questionnaire is designed to get gross information from a large group, the focus group gets detailed information from a limited group. Focus groups can be used to (1) present results of initial surveys generally used in needs assessment, or (2) the summary of an evaluation for clarification of responses, or (3) to establish causes for each response. This method is particularly useful in needs assessment when trying to move from a general need to the specific needs that can be met through CME. In the evaluation phase, focus groups can help you move past what may have worked well (or poorly) to identify exactly why. Most surveys and written evaluations do not yield this depth of information.

Whether used for needs assessment or evaluation, a significant side benefit is that those involved will learn more about the complexity of, and your commitment to, developing quality CME. An important, and often overlooked, step in the process involves getting back to each person in the group to let him/her know what action is being taken or why no action is possible at this time. This step is crucial in reinforcing the fact that you value the individual's opinions/suggestions.

Care must be taken to build trust as with any group process. If possible the CME director should conduct these sessions. It not only provides first-hand information not distorted by the report of anyone else, but it is also an opportunity to develop personal relationships with your audience. The long-term benefit of these relationships is very difficult to accurately measure, but it is obvious to those who have used the technique. This also helps establish a feeling of ownership among those chosen to help.

**—Contributed by Charles E. Osborne, Children's National Medical Centre**

## CME RESEARCH UP NORTH . . .

A half-day session devoted to research in CME was held as part of the Standing Committee on Continuing Medical Education's program at the Association of Canadian Medical Colleges' Annual Meeting on October 3, 1990.

Robert Fox, University of Oklahoma, presented an eloquent keynote address: "New Research Agendas for CME: Organizing Principles for Self-directed Curricula." While CME research has been prolific, Dr. Fox noted that little attempt had been made to integrate the perspectives contained within the theories into a comprehensive model that would help CME practitioners to understand how physicians design their own curricula for change in practice. Five key questions with relevant theories and literature were discussed: Why do physicians change their practices? What stages of self-directed learning do physicians go through? Why do physicians go through learning in the change process? Why do they participate in formal programs? How do physicians learn from their experiences?

A series of short presentations followed. Ian Purkis, Dalhousie, demonstrated a computerized patient management problem system including authoring of such a system. From Toronto, Jane Tipping discussed how an educational consultant in the CME office could make CME teaching more effective while Michele Hudon described the creation of a CME resource centre designed to assist the CME office, its personnel and its learners.

George Bordage, Laval, drawing on the results of a questionnaire-based study to a large number of general practitioners in Quebec, discussed the problems they perceived in practice and suggested that this information could be used to design more effective CME programs.

Colin R. Woolf, Toronto, presented the perceived educational needs for CME of semi-rural and urban

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***Material Coordinated by Jocelyn Lockyer**

## CME RESEARCH UP NORTH . . .

*Continued from previous page (4-A)*

physicians in Ontario, reviewing the similarities and differences between the two groups. John Parboosingh, Calgary, described a new initiative wherein a group of family physicians are working together to identify real educational needs using a multi-stage process consisting of an initial questionnaire, interview, and stimulated case recall interviews. The end result will be new educational programs designed and taught by family physicians.

Jocelyn Lockyer, Calgary, concluded the program with a description of a computerized database of questions emanating from their Medical Information Service (a literature searching service). The question bank is available to other CME offices to assist in planning courses.

**—Contributed by Jerry Tenenbaum, University of Toronto.**

## BOOK REVIEW

*Focus Groups as Qualitative Research, by David L. Morgan. Sage University Paper Series on Qualitative Research Methods, Vol. 16. Beverly Hills, CA: Sage, 1988*

AUDIENCE: CME researchers and providers involved with needs assessment, program development, and evaluation.

The focus group is a qualitative research technique that is frequently associated today with the field of market research, despite its origins in sociology in the 1940's. In recent years social scientists have "rediscovered" the technique because of its versatility. In this volume, the author, a sociologist at Portland State University, provides a cogent description of focus groups: what they are, their uses in social science research, how to go about conducting them, and how to analyze and report the data derived from them.

Focus groups fall into the general category of group interviews. "The hallmark of focus groups is *the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group.*" (p.12)

With this distinction in mind, Morgan discusses a variety of potential uses of focus groups, all of which are applicable to CME: (1) to explore a new field or research setting, (2) to generate hypotheses for research, (3) to develop or refine interview schedules and surveys, (4) to serve as a basis for selecting individuals for more in-depth interviewing, and (5) to clarify findings of current or previous research.

As described by Morgan, focus groups are versatile. They may be used as a self-contained data collection method, as part of a larger study, or as an adjunct to other data collection methods. Depending on their use, their results may stand alone or be used in triangulation with data from other sources. Strengths and weaknesses of the method are discussed, as well as ways in which focus groups may be used in conjunction with other data collection methods (participant observation, surveys, interviews).

The second half of the book deals with practical issues related to planning and conducting focus groups (as with CME, the time and effort spent on planning pay off in the long run). In addition to discussing the current state of focus groups. Morgan looks at ways in which the technique may be developed further in the social sciences, and also identifies key resources for those interested in more information about focus groups.

*Focus Groups As Qualitative Research* is one volume in the Qualitative Research Methods Series which is published regularly by Sage. These volumes are brief, to the point, written with a minimum of jargon, and serve as excellent introductions to qualitative research methods in the social sciences. As it becomes increasingly evident from the literature that qualitative research methods may be fruitfully applied to CME, a subscription to this series should be considered for the CME bookshelf.

**—Contributed by Deborah Jones, Jefferson Medical College**

## WOULD YOU LIKE TO COLLABORATE?

*Can Practice-Based Questions Be Used To Focus CME Programs on the Educational Needs of Physicians?* Lockyer J, Gondocz T, Jennett P, Badertscher B, and Parboosingh J.

The University of Calgary has generated a database of more than 400 questions submitted by practicing family physicians to their Medical information Service. The questions cover all aspects of medicine and were derived from both urban and rural settings. Reading material reviewed by a consultant was sent to the physicians in response to the query.

The data bank of questions has been used in a preliminary way by the Office of CME, University of Calgary, in the design of short courses and in the formulation of directions to faculty presenting CME lectures.

The University would like to determine whether the data bank of questions (1) can be used to design educational programs in other locales, (2) are relevant to clinicians in other parts of North America, and (3) will yield a better educational product than courses planned in traditional ways.

Anyone willing to collaborate on the project is asked to contact Jocelyn Lockyer, Continuing Medical Education, University of Calgary, 3330 Hospital Dr. NW, Calgary, AB T2N 4N1. Phone: 403/220-7240. FAX: 403/270-2330. General inquiries about the service are also welcome.

# MEDICAL SCHOOL CME COOPERATION WITH INDUSTRY*

***Position Paper Developed by the SMCDCME Committee on Industry chaired by Martin Shickman, UCLA. Presented and officially approved at the Society's Business Meeting in San Francisco, October 21, 1990.**

Medical schools highly prize and jealously guard and protect their credibility and integrity in all their activities. Whether it is the teaching and training of future professionals, the conduct of scientific research, the care of patients, or the continuing education of practicing physicians, medical schools look on each and every program as *their own*. This is true regardless of where support comes from, and regardless of the kind of joint venture arrangements that can be made. It is the medical school that is accountable for the quality and appropriateness of programs offered under its imprimatur. If these programs are successful, the medical school will be pleased to share the credit. If something goes wrong, it is the school's position that all of the responsibility and all of the blame belongs to the medical school. It is essential that commercial companies understand this point of view, and thus participate as partners committed to the highest imperatives of quality. Such a partnership will certainly serve the best interests of both industry and the medical schools.

As applied to CME, this point of view derives not only from the philosophy and policies that define medical school CME, but from the requirement of the ACCME (see ACCME Guidelines for working with commercial companies). Medical schools (and other agencies that offer approved CME) receive their accreditation from the ACCME. The medical school's status as an "approved provider" is determined by the school's compliance with an extensive set of requirements set up by the ACCME (see ACCME Essentials). Each school undergoes a comprehensive review by the ACCME at defined intervals varying from one to six years—at shorter intervals for those schools which are considered marginal, and at six years for those schools whose performance is considered to be commendable.

This status as an approved provider *is not transferable*. Thus medical schools *are not* in the business of accrediting or approving programs developed by other agencies, or franchising other agencies to develop programs in the name of the medical school. Medical schools *are* in the business of developing, producing and evaluating CME. This is the medical schools' primary responsibility if their imprimatur is to be attached, whether or not the school is in partnership with a learned society, a governmental agency, a drug or equipment manufacturer, or an entrepreneurial CME company.

As a consequence of this reality, while it is perfectly appropriate for pharmaceutical or equipment manufacturers to approach medical schools for programs which relate to a particular company's proprietary interests, the determination of need for the program, the range and specifics of its content, the selection and/or the approval of the faculty, the choice of educational methodologies and formats, and the promotional activities and materials must all be under the control of the medical school.

All external financial support for CME should be provided through the CME office or through the Dean's Office, depending on individual institutional policy. The financial support of the commercial company must be acknowledged on the promotional material. The use of scientific names in discussing pharmaceutical agents is preferred, and generally should be used. Brand names may be used in those instances where scientific names are so unfamiliar that the use of them causes confusion. In all instances, a balanced discussion of all therapeutic options should be presented to CME participants. (See guidelines of ACCME, SMCDCME, Canadian Medical Association (CMA), for co-sponsorship with commercial companies.)

The proper implementation of these principles requires that the medical school be involved early on in the planning process. Presenting the medical school with a virtually completed program, regardless of its quality, need and appropriateness, should trigger an automatic refusal of the medical school to participate. The process of partnership is best implemented by contacting the medical school CME office directly and early on (see SMCDCME list of departments and directors).

The CME office exists not only because it is an efficient and effective means for producing university-based CME, but also because it is required under Essential #6 of the ACCME Guidelines. This Essential mandates "the documentation of an organizational structure for CME . . . (and) . . . the designation of an entity for CME." The contacting of specific professors in the medical school by the commercial company before the CME office is contacted, or the contracting with entrepreneurial CME intermediaries by commercial companies, often causes considerable problems for the medical school and the commercial company. This may, and often does, lead to compromise of the quality of the program and the thwarting of interests and intentions of the commercial co-sponsor—and even the withdrawal of the university from the venture.

In all instances, the CME office will approach its potential commercial partners with flexibility and with a cooperative spirit, but the specifics of the relationship will have to conform to the principles outlined above. The guidelines under which a medical school CME operates are not intended to impose fixed limits on the manner in which the schools develop and produce their programs, but to insure that the programs are produced

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# Reflecting on CME Ethics

***Editor's Note:*** **We're grateful to Past President Richard Caplan for sharing copies of his series of articles published in *Iowa Medicine* and for his granting of permission to reprint some of them in *Intercom.* We think this letter to a pharmaceutical representative is particularly appropriate right now in view of recent attention to industry/CME relationships.**

Last month I raised some questions to draw attention to (un)ethical practices in the world of CME. Because of an invitation that recently came to me, I decided to "sound off." I hope my letter, printed here, will prompt you to some personal reflection on this issue. Of course, I hope you agree, or will come to agree. If you do, please join my little crusade at each opportunity, and you have many. I was cheered at a recent meeting of the IMS Education Committee that the members agreed with me and in fact suggested I use this column (once, anyway) for this purpose. (I chose to eliminate the name of the addressee and his company, *this time,* from the letter.)

Dear Mr. _____, President:

My mail has brought me what seems a kind invitation from your company. You offered travel, hotel accommodations, meals, and other arrangements for me and my guest to attend a meeting in Naples, Florida, where I would spend 3½ hours on 2 mornings to hear (presumably) scientific talks about antihistamines for antiallergic therapy and trials of your new drug, _____.

Such an offer seems not merely kind, Mr. _____, but I also consider it unethical. If that word seems harsh, perhaps you might prefer "payola" or "bribery." I'm sorry if my reaction, and my honesty in reporting it to you, either surprise or offend you. But I believe you deserve to know that there are at least some of us physicians who recognize your all-too-transparent effort to buy my interest and allegiance for your product.

As director of continuing medical education for a college of medicine, I have a large personal and professional commitment to help educate the community of practitioners about new drug products. Neither my college nor I are philosophically opposed to accepting educational grants from your company or others, as long as you do not try to dictate program personnel or content. I do not protest that you advertise in journals, or that you send company representatives to "help educate" me. So the line between appropriate and inappropriate is sometimes, I grant, hard to discern. But an expense paid trip to Florida for me and my guest? — come now, Mr. _____, that is clearly beyond defending. That such practices by pharmaceutical and equipment manufacturing companies are increasing, and that there are physicians who accept such invitations is not a justification; it is rather cause for great lamentation. The great majority of my physician colleagues, I believe, can afford to pay for their own vacation trips, rather than receive them in such a tainted fashion, using your company's funds which all-too-obviously must come from the pockets of patients. That this practice was recently described and condemned on the pages of the *New York Times Magazine* (November 5, 1989, page 88) might perhaps help awaken you to the response of the paying public.

I would wish the nation's pharmaceutical companies might realize that the mode of advertising I am reacting against, challenging as it does the integrity of the medical profession, is not in the best interests of the company, the physicians, or the public. Naturally, I would be happy to hear from you.

Sincerely,
Richard M. Caplan, M.D.
Association Dean of Continuing Medical Education
University of Iowa School of Medicine

March 1990

## Cooperation with Industry

*Continued from page 5*

with integrity and at the highest level of quality.

The policies that govern the production and co-sponsorship of enduring materials (printed materials, slides, film, audio and video tape and computer-assisted CME programs) are virtually the same as those governing the accredited live conference (see ACCME Guidelines on interpreting the Essentials as applied to Enduring Materials).

However, the policies which apply to enduring materials also recognize the fact that their content is perishable over time. The Essentials thus require that a process be in place to determine when these materials are outdated and therefore no longer useful for CME. Some of these requirements include:

1. The re-evaluation of these materials at least once every three years—and more frequently if indicated by scientific developments.

2. The accredited sponsor must indicate how the findings from the review process were used to revise and update the material.

3. The date of the original release of the material must be displayed after the title, along with the date of the most recent review and revision.

The accredited sponsor for enduring materials (in this instance, the medical school) is not only accountable for all of the ACCME requirements applicable to live programs, but must also assume ongoing responsibility for the planning, evaluation and proper use of enduring materials. (For other technical details and requirements, see ACCME's Statement on Interpreting the Essentials for Enduring Materials.)

Medical schools welcome the participation of commercial companies as CME partners. Partnerships based on the principles discussed in this statement will be of benefit to commercial companies, medical schools, the participating physicians, and above all, to our patients and the public.

# New Members and Change in Member Status

## Approved at Business Meeting, October 21, 1990

### EMERITUS MEMBERSHIP

**Colin R. Woolf, M.D.**
Toronto, Ontario, Canada

### VOTING MEMBERSHIP

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**Jerry Tenenbaum, M.D.**
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### CHANGE IN STATUS

**Weldon D. Webb**
University of Missouri - Columbia
From Voting to Associate

**Barry W. Kling**
University of Missouri - Columbia
From Associate to Voting

**Albert J. Finestone, M.D.**
Temple University
From Voting to Associate

## SPRING PROGRAM WILL HIGHLIGHT LEADERSHIP

### By Paul Lambiase, Program Chairman

A very special program is now being planned for the Spring Meeting of the Society in Toronto, April 26-29. Following one of the key goals identified in the Society's strategic plan, the focus of the Spring Meeting will revolve around leadership.

To facilitate our growth and development as a profession, as well as an organization, it is vitally important that we be able to identify and utilize resources uniquely available within medical schools. Before this can be accomplished, we need to better understand the roles we play locally, regionally, and nationally, and how our energies, enthusiasm and abilities—in other words, our leadership—can most effectively bring this about.

The tentative format for the April meeting is as follows:

| | | |
|---|---|---|
| Friday, April 26: | Morning: | Executive Committee meeting |
| | Afternoon: | Retreat |
| Saturday, April 27: | Morning: | Committee meetings<br>Regional meetings |
| | Afternoon: | Free for specially organized tours to McMaster Health Sciences Centre and Niagara Falls |
| Sunday, April 28: | Morning: | Seminar on Leadership |
| | Noon: | Luncheon and Business meeting |
| | Afternoon: | Seminar on Leadership |
| Monday, April 29: | Morning: | Research portion of the program consisting of an invited lecturer; discussion; and 3-5 short presentations |

Be sure to set aside the dates and plan to attend! More information will be available in the April newsletter.

If you have any questions or suggestions for the Spring Meeting or future programs, please contact: Paul Lambiase, University of Rochester School of Medicine & Dentistry, (716) 275-4392. Your input is encouraged.

**Only a color photo could do justice to the beautiful lobby of the King Edward Hotel. Fully restored to Edwardian elegance, it features inlaid marble floors, a collonaded rotunda, and vaulted ceiling.**

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**SOCIETY OF MEDICAL COLLEGE DIRECTORS OF CONTINUING MEDICAL EDUCATION**
**515 North State Street, Chicago, Illinois 60610**

**Spring Meeting:**
**April 26-29, 1991**
**Toronto, Ontario, Canada**

**PLAN TO ATTEND!**


Paul J. Lambiase
Director, Continuing Professional Education
Univeristy of Rochester
School of Medicine & Dentistry
601 Elmwood Avenue, Box 677
Rochester NY 14642

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*First Class Mail!*

**PLEASE CHECK THIS MAILING LABEL! Are your name and address correct? If not, please notify Secretary-Treasurer Robert E. Kristofco, Associate Director of CME, University of Alabama-Birmingham, Rm. 127-CHSB, 20th Street South, UAB Station, Birmingham, AL 35294. Telephone 205/934-2687; FAX 205/934-1939.**