INTERCOM

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

Volume 5, Number 2 April, 1991

INNOVATIVE PROGRAM TO BE OFFERED AT ANNUAL MEETING, APRIL 26-29

THE SPRING MEETING in Toronto, April 26-29, will provide a priceless opportunity for evaluation of members' individual leadership practices. As explained in the meeting brochure, each pre-registrant will receive a copy of *Leadership Practices Inventory* by Kouzes and Posner, authors of *The Leadership Challenge: How To Get Extraordinary Things Done in Organizations.*

The LPI should be returned to the National Leadership Institute in Adult and Continuing Education in Atlanta for compilation. Then a profile will be developed to be used in each individual's Personal Development Plan.

This valuable service is being provided through the Georgia Center for Continuing Education, which established the National Leadership Institute, with funding assistance from the W.K. Kellogg Foundation.

Principal faculty member assisting Edye Stolz, project manager, with this activity is Charles Palmgren, Ph.D. senior consultant for ODR, Inc., a national firm devoted to leadership development within business and education.

After 27 years as a consultant and educator, Dr. Palmgren is an acknowledged authority on managing organizational change. Drawing on his diverse background, he is able to provide expert counsel to public and private organizations, Fortune 500 companies, governmental agencies, and financial institutions.

Dr. Palmgren is a noted author on managing organizational change. He has contributed to the *Journal for Creative Change* and the *Journal of Drug Education,* and also wrote one chapter in the book entitled *Creative Change* by Broyer and Minor (1982).

The program on Saturday morning, April 27, will be devoted to research. It will open with a keynote presentation by Goeff Norman, professor of clinical epidemiology and biostatistics at McMaster University, who serves as chairman of the Program for Educational Development.

After an hour-long session for the presentation of research papers, John Parboosingh, will provide an overview of "The Maintenance of Competence Project" of the Royal College of Physicians and Surgeons of Canada. He will also discuss "Physician Adoption of Innovation: A Research Methodology." Robert Fox will outline "Opportunities for Research in CME" at the same session.

On Sunday, April 28, both morning and afternoon sessions will be devoted to Individual Leadership Practices. Following a luncheon sponsored by the Municipality of Metropolitan Toronto, the Society Business Meeting will be held.

The Program Committee gratefully acknowledges the Audio Digest Foundation's continuing support of the Society's educational activities.

Comments from Paul Lambiase, Program Chairman

Much attention has been focused recently on leadership issues. It was the first goal mentioned in the report of the Society's Strategic Planning Committee, distributed in the fall of 1989. It has been the topic of articles in our own professional publications and of workshops and sessions at national CME meetings.

As individuals, we need to understand and use sound leadership practices in our efforts to gain greater recognition and acceptance for the role that CME plays within organized medicine. Within our organizations, we need to develop our understanding and abilities in order (1) to interact effectively with other key players, and (2) to become increasingly visible and and sought after for our own professional expertise. Nationally, it is vital to have a current understanding of the major issues confronting us and how we can help to shape the future in which we will need to live and work as CME professionals.

The Program Committee, in devoting a major portion of the Spring Meeting to Individual Leadership Practices, directly addresses two key issues outlined in our strategic plan: (1) leadership and (2) professional development of the membership. The Program Committee strongly encourages your active participation in use of the Leadership Practices Inventory (LPI) offered as a part of the program. Your reactions and feedback to this format will help to shape future educational activities of the Society.

A Word About the Retreat, Monday, April 29

All registrants are encouraged to participate in the Spring Retreat. This session offers an informal opportunity for airing common concerns and issues. It is also one means used to assist in identifying topics that might be further addressed as a formal part of future Society programs.

Your input and ideas, as well as your willingness to share in this format, are basic to the success of the retreat which in many ways reflects the origins of our Society.

President's Comments

Flexner, Faculty and Finance

State of the Society. During the past year, the Society has provided leadership in several areas. We are moving toward identifying a new Editor for *The Journal of Continuing Education for the Health Professions* to follow Malcolm Watts. Through several projects, we are developing a broader base for research, education and the administrative activities of the Society. A permanent office has been established. An organization for CME Providers in North America is being discussed. The Society will be incorporated as a C-3 non-profit organization. We have improved our relationships with pharmaceutical colleagues. We have completed most of the objectives in our Strategic Plan. Significant accomplishments have been made on many issues.

In addition to our focus on Research, Education, and Administration, we must undertake two major new initiatives: (1) A grand design for CME in North America and (2) stronger linkages with, and support from, our faculty and administration for academic-based CME.

Flexner-Type Report on Continuing Medical Education. Continuing Medical Education has provided leadership in Continuing Professional Education. At the same time, CME has undergone dramatic changes: Growth in numbers of programs, greater numbers of providers, research into effective CME interventions, and an expanded interest in CME as a response to remedial needs of physicians (personalized CME). In the future, recertification may influence how CME is delivered.

These are only a few of the dynamic issues that have increased the visibility of CME as a field of study and perhaps as a discipline.

For all these reasons, it seems appropriate to establish a Commission on CME to study our accomplishments and outline future directions for CME in North America. Both the Flexner Report and the GPEP Report, plus others, gave some future vision to medical education in North America, but each emerged for different reasons.

I do not think CME is in a confused state, but I *do* think there are several dimensions that need a sharper focus for the future. Otherwise, we *will* have confusion in CME, especially academic-based CME.

The attention of a Commission must be devoted to the process, structure, and outcome of CME. The focus must be on the recipient of the educational intervention and how we can maintain the quality of medicine for the benefit of society. A study may be highly critical of some of our actions. In addition, it will find prominent highlights of our behavior as well. If we are to succeed in the future, we must decide where we want to be.

The idea of a Commission will be discussed in Toronto and, perhaps, initiated in Birmingham at the 1992 Congress on CME.

Faculty and Administrative Support. To me, one thing is clear and timely about our future in academic CME: Each of us must garner the support of our administration and our faculty if that future is to be a bright one. These two (administration and faculty) go hand-in-hand and must be cultivated together nationally as well as at our own institutions. We have begun with our admission to the Council of Academic Societies (CAS). By taking an active role in the CAS, we can provide leadership nationally in a joint effort with our faculty.

Another national initiative must be to work with the Council of Deans, perhaps on the Flexner-like study proposed earlier. My sense is that CME may be an increasingly important issue in academic medicine in the future and that our relationship with the Council of Deans will be increasingly important as well.

That leaves our work at home with our administration and faculty. Daily we must work at contributing to each of these for the benefit of our individual institutions. It will be a slow process, but one to which we must make a firm commitment. Our success and our reputation nationally will be as good as we want it to be and as we make it in our own institutions.

Research Funding. Finally, it will be essential for the

Intercom is published on a quarterly basis by the Society of Medical College Directors of Continuing Medical Education. Supported in part by an educational grant from the Department of Professional Education/Scientific Communications, Marion Merrell Dow, Kansas City, Missouri.

Subscription rate: $20 per year

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Jocelyn Lockyer, Research Notebook

Society to secure funding for its principal activities: Research, Education and Administration. Each will require a creative initiative to establish them solidly, and we are moving in that direction.

Last year the Research Committee proposed that a Research Foundation be established by the Society. After reviewing the proposal, it was clear that the establishment of such a foundation was not in the best interests of our organization, since the Society itself can serve the same purpose. That is a commitment to which our leadership must pledge itself and one on which I intend to focus my energies for the next three years. We should be able to establish a fund for special projects, individual projects, young investigators' awards, and other related CME research. With support from outside sources and leadership from the Research Committee, I hope we can achieve a substantially funded research effort by 1995.

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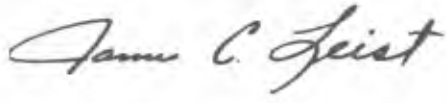
As this issue is under way, our Society is preparing for its Annual Meeting in Toronto, Canada. Paul Lambiase, Robert Fore, Nancy Bennett and members of the Program Committee have developed an excellent program on Leadership, with a half-day on CME research. Dave Davis at McMasters University, and Jerry Tenenbaum and Sandra Leith at the University of Toronto have organized plans for a superb visit to Toronto. I look forward to seeing all of you there.

Thank you for the opportunity to serve as your President during the last year. It has been the highest honor of my professional career.



FOUR EXECUTIVE COMMITTEE MEMBERS TO BE ELECTED. . .

Last fall the Bylaws were revised to eliminate the title of President-elect and to provide instead for the selection of a First and Second Vice-President, each to serve a one-year term. No change was made in the customary plan for staggered two-year terms for Regional Representatives.

Accordingly, the Nominating Committee, chaired by Past President Robert Cullen has presented the following slate of nominees to be voted on at the Annual Meeting:

For First Vice-President	Martin Kantrowitz William Matory
For Second Vice-President	William E. Easterling, Jr. R. Van Harrison
For Midwestern Regional Representative	Barton W. Galle William F. Gust
For Western Regional Representative	Rosalie Lammle J. Brian O'Toole

Biographical information is being sent to voting members of the Society.

ACME Annual Conference Presents Research Material on Evaluation and Needs Assessment . . .

Even though the 1991 ACME meeting in San Francisco, January 22-26, was designed as a program for CME practitioners in a variety of settings, the over-all configuration of the meeting became the ultimate self-directed learning experience for CME providers. The program was primarily workshop-based with a unique blend of content. A research track was available for the person who had heard enough of the "nuts and bolts" of CME (teaching medical staff to teach, negotiating the perfect hotel contract, or designing the best brochure).

The program featured CME professionals who are members of ACME or SMCDCME—or both.

Robert Razkowski, Henry Slotnick and Clayton Jensen discussed the components of a successful survey. They focused on the essentials: When will survey methods answer the questions? How do you define the population and select a sample? How do you design the questionnaire? Is a reasonable response rate possible? And how can one ensure the quality of the data and its analysis?

Jocelyn Lockyer and Richard Swanson discussed getting started on evaluation in the CME office. After comparing definitions of research and evaluation, they presented a multi-stage plan for beginning and working through actual examples of studies. They suggested that beginners start small, use available data and resources, call in design/methodology help, focus and narrow the question, and select a project that is interesting and simple enough to succeed even with limited resources.

Michael Rodemyer and Linda Hummel examined the need to evaluate evaluation, the politics of evaluation, the questions and issues that might be addressed, the methods available, and use of the results.

Two sessions were conducted on needs assessment. Using examples from typical surveys, Jane Mihelic and Mildred Fleetwood provided a number of tips to help the beginner frame the question, identify the population to be surveyed, budget the study, increase response and use the results. Donald Cordes presented the basics of a needs assessment plan, recognizing that needs assessment should be part of an over-all strategy involving learners, teachers, patients and others. Noting that only two methods exist to survey people—questionnaire and interview—Cordes presented the advantages and disadvantages of both.

Finally, for the elite researcher Martin Kantrowitz ran a participatory workshop on future directions for CME research.

While this was certainly not the typical research meeting, it was a chance to recall the basics and begin to reflect on the next evaluation project to be undertaken.

—Contributed by Jocelyn Lockyer, University of Calgary

GUIDELINES FOR COMMERCIAL SUPPORT OF CONTINUING MEDICAL EDUCATION

Guidelines for commercial support of CME were initially approved by ACCME in June 1984. Following the Industry/CME Provider Conference held in Chicago, August 8-9, 1990, a Task Force was constituted to suggest revision of the Guidelines. Dennis Wentz was appointed as chairman, with Robert Cullen as vice-chairman. Seventeen other prominent individuals—nine CME providers and eight pharmaceutical representatives—agreed to serve as Task Force members. Here are the final Guidelines as approved by ACCME on March 16, 1991.

PREAMBLE

The purpose of continuing medical education (CME) is to enhance the physician's ability to care for patients. It is the responsibility of the accredited sponsor of a CME activity to assure that the activity is designed primarily for that purpose.

Accredited sponsors often receive financial and other support from non-accredited commercial organizations. Such support can contribute significantly to the quality of such activities. The purpose of these guidelines is to describe appropriate behavior of accredited sponsors in planning, designing, implementing, and evaluating certified CME activities for which commercial support is received.

GUIDELINES

1. Accredited sponsors are responsible for the content, quality, and scientific integrity of all CME activities certified for credit. Identification of continuing medical education needs, determination of educational objectives, and selection of content, faculty, educational methods and materials is the responsibility of the accredited sponsor. Similarly, evaluation must be designed and performed by the accredited sponsor.

2. The accredited sponsor is responsible for the quality, content, and use of enduring materials for purposes of CME credit. (For the definition, see the ACCME "Guidelines for Enduring Materials.")

3. Presentations must give a balanced view of all therapeutic options. Use of generic names will contribute to this impartiality. If trade names are used, those of several companies should be used rather than only that of a single sponsoring company.

4. When commercial exhibits are part of the over-all program, arrangements for these should not influence planning nor interfere with the presentation of CME activities. Exhibit placement should not be a condition of support for a CME activity.

5. The ultimate decision regarding funding arrangements for CME activities must be the responsibility of the accredited sponsor. Funds from a commercial source should be in the form of an educational grant made payable to the CME sponsor for the support of programming. However, all support provided in relation to the certified CME activity must be made with the full knowledge and approval of the accredited sponsor. Payment of reasonable honoraria and reimbursement of out-of-pocket expenses for faculty is customary and proper. Commercial support must be acknowledged in printed announcements and brochures; however, reference must not be made to specific products. Following the CME activity, upon request, the accredited sponsor should be prepared to report to each commercial supporter and other relevant parties, and each commercial supporter to the accredited sponsor, information concerning the expenditures of funds each has provided.

6. Commercially supported social events at CME activities should not compete with, nor take precedence over, the educational events.

7. An accredited sponsor shall have a policy on conflict of interest applicable to CME activities. All certified CME activities will conform to this policy.

8. In an activity offered by an accredited sponsor, it is not permissible to provide for travel, lodging, honoraria, or personal expenses for attendees. Subsidies for hospitality should not be provided outside of modest meals or social events that are held as part of the activity.

Scholarship or other special funding to permit medical students, residents, or fellows to attend selected educational conferences may be provided, as long as the selection of students, residents or fellows who will receive the funds is made by either the academic or training institution or the accredited sponsor, acting with the concurrence of the other.

TASK FORCE MAKES RECOMMENDATIONS FOR FUTURE COLLABORATION . . .

The Task Force on Pharmaceutical Industry/CME Provider Collaboration met at Miami Beach, Florida, on February 15, 1991, to prepare the final revision of the Guidelines for re-submission to ACCME. The meeting included a free-ranging discussion of the best mechanisms to assure compliance, once the Guidelines were approved.

Agreement and consensus were achieved on the following:

1. A new enforcement group would not be in anyone's best interest.

2. Mechanisms exist within ACCME and the Pharmaceutical Manufacturers Association to monitor compliance. Within ACCME, a system exists for dealing with letters of compliance, or known abuses of accreditation by accredited sponsors. When PMA receives a formal complaint, the letter is transmitted directly to the Chief Executive Officer of the company involved, and the problem is usually resolved.

3. It was agreed that the ACCME staff should also contact PMA directly if they suspected a violation by a

Continued on page 5

RESEARCH NOTEBOOK*

AN UNUSUAL RESEARCH TOOL

The Research and Development Resource Base (RDRB)

Have you ever wondered if someone else has tackled the same research question? Have you started developing a study only to realize you did not know the literature in the field? What about the day you dreamt of a new CME intervention only to wonder if anyone else had already tried it?

The Research and Development Resource Base (RDRB) was created to help you. Prompted by the question. . ."Does CME work?" that underwrote the development of an annotated bibliography of CME interventions, the RDRB was formed as the direct result of the support in 1985 from the SMCDCME Research Committee.

The RDRB currently exists in computer-accessible format at McMaster University. More than 800 articles are extensively key worded, many are annotated, and all of them are categorized in several major sections:

- Needs assessment
- Intervention and formats (curriculum strategies, administrative maneuvers, and instructional techniques)
- Evaluation assessments
- Learner characteristics
- Learning environment (practice site, funding)
- Miscellaneous, including a growing section of the management of research

Components of the RDRB have been significantly enhanced by the addition of material from adult and continuing professional education. This input has been coordinated by Bob Fox at the University of Oklahoma. The RDRB is derived from regular searches in MEDLINE, ERIC, NTIS and the Social Sciences Index; and are added to by scrutiny in the non-indexed literature.

Access to the RDRB is easy. Any member of the SMCDCME can write or phone for a search of the current RDRB database at no cost. Cost of reprints or extensive non-RDRB searches (e.g., ERIC) are borne by the user.

For a search or further information, call: Marlene Rogers, McMaster University, 1200 Main Street West, Health Sciences Centre, 2E19, Hamilton, Ontario, L8N 3Z5. Phone: (416) 525-9140, Ext. 2108. FAX: (416) 528-4727. EMail: @ MARLENE SSCVAX.CIS.McMaster.CA

—Contributed by David Davis, McMaster University

A RESEARCH BOOK OF INTEREST

Data Quality in Longitudinal Research, David Magnusson and Lars R. Bergman (Eds), Cambridge University Press, 1990.

Research in CME is often concerned with the relationship between change in physician practice behaviors and educational intervention(s). Because the documentation of change in clinical practice often requires CME researchers to collect data from or about the same individuals on more than one occasion, CME research is often longitudinal in nature.

Data Quality in Longitudinal Research is the third in a series of edited works based on workshops held by the European Network on Longitudinal Studies on Individual Development. It is a collection of papers explicitly concerned with judgments regarding the requirements for quality data in longitudinal research. Following an introductory chapter that broadly outlines general issues of concern in longitudinal research, the editors have organized the workshop papers into three sections.

Part I contains five chapters which deal with the quality of psychiatric data, epidemiological longitudinal research, pediatric research, research on alcoholism, and research on socially undesirable behavior. Part II presents two chapters on enduring problems in longitudinal research: drop-out and attrition. The final section provides six chapters on the relationship of data quality and issues of research design and methods.

The introductory chapter, authored by Bergman and Magnusson, is clearly written and provides an excellent general overview of key issues confronting those who are conducting longitudinal research. One of these, time, is a critical component of longitudinal research that imposes additional constraints on the research process. The impact of time on issues associated with the validity and reliability of measures, sampling, and errors of measurement are discussed succinctly and accompanied by illustrative examples. For those who are relatively new to this type of inquiry, the authors have provided a substantial list of references. Regardless of the level of intellectual and practical involvement of readers with longitudinal research, all should benefit from the balanced viewpoint of these two senior level psychologists.

Unlike many edited volumes, this work achieves coherence across the three parts. Fundamental issues covered in a general, more abstract fashion in the introductory chapter are returned to in an applied, more concrete manner in the chapters comprising Part I. These chapters highlight and illustrate areas of inquiry in which longitudinal data are frequently used. In Parts II and III many of these issues are visited again at a more abstract level. This movement across different levels of abstraction for the same issue creates a useful dialectic.

(Continued on reverse side)

***Material Coordinated by Jocelyn Lockyer**

1991 ARTICLES WORTH READING

Improved patient outcome is the goal of continuing medical education. It is clear from the literature that single educational interventions rarely cause profound changes in clinical practice. Instead the synergism between a number of interventions, collegial discussions, personal commitment to change, and a supportive environment results in change. For CME providers, it's important to be aware of the research that examines physician behavior so that we can ultimately be more effective in improving patient care.

Baumann AO et al, *Overconfidence Among Physicians and Nurses: The 'Micro-Certainty, Macro-Uncertainty' Phenomenon.* Social Science and Medicine 1991, 32:167-174

The authors report on two studies of overconfidence. In the study involving physicians, a series of clinical vignettes were presented to physicians on the management of breast cancer. The physicians were asked to indicate the recommended treatment and how much uncertainty they felt about their choice of optimum treatment. Baumann et al found considerable variation in treatment choice among physicians but high levels of certainty that their treatment choice was correct. The study results suggest that a woman could receive very different treatment recommendations, depending on which physician she consulted. Yet, the physicians were all very confident that they had made the right choice even in the face of massive disagreement among them.

This study has implications for those setting up quality assurance programs. Overconfidence regarding current treatment approaches, even in the light of published accounts of controversy, may impede the reflection physicians need to implement quality assurance programs. Resistance to the implementation of such programs may be based on a failure to recognize that clinical practices are as widely diverse as they are and that some standardization is warranted.

Schwartz JS et al, *Internists' Practices in Health Promotion and Disease Prevention.* Annals of Internal Medicine 1991; 114:46-53

An extensive mail survey was designed to estimate internists' use of disease prevention and health promotion activities, and to explore demographic, professional, behavioral, psychological, cognitive, and organizational factors associated with the use of such practices. Members and Fellows of the American College of Physicians participated in the study. They found that internists used effective preventive interventions less frequently, and ineffective practices more frequently, than experts recommend. Internists' use of health promotion and disease prevention activities is associated with habit, attitude, and a lack of adequate knowledge. Younger age of physicians, general internal medicine practice, and personal health promotion and disease prevention practices were strongly associated with more appropriate use of recommended practices.

This study has implications for those developing educational programs in preventive medicine. Educational programs in themselves may be insufficient. Such programs might be supplemented through efforts to improve the physician's personal health practices, to focus on the patient, and to include reminder systems for physicians.

Norcini J et al, *Changes in the Medical Knowledge of Candidates for Certification.* Annals of Internal Medicine 1991; 114:33-35

The study examined the results of candidates for certification who took the 1983 through 1988 examinations in internal medicine. Authors were interested in determining whether the medical knowledge of candidates from different types of medical schools changed over the study period. Norcini et al found that the scores of medical school graduates in the U.S. decreased, while the scores of non-U.S. citizens who graduated from foreign medical schools increased. Trends in the performance of graduates of Canadian and osteopathic medical schools and of U.S. citizens who graduated from foreign medical schools were not discernible.

If the downward trend continues, patient care may ultimately be affected. Educators need to consider ways of enhancing baseline knowledge, both in residency and in practice settings, to ensure that care is not jeopardized.

Hadley J et al, *Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use and Outcome,* JAMA 1991; 265:374-379

Discharge abstracts for 592,598 patients hospitalized in a national sample of hospitals were analyzed in order to investigate the association between insurance status and condition on admission, resource use, and outcome. In the majority of instances, the uninsured had a significantly higher risk of in-hospital mortality at the time of admission than did the privately insured. The uninsured were less likely to undergo high cost or high discretion procedures and less likely to have normal results on tissue pathology.

While the authors caution that additional research is needed to compare care provided between insured and uninsured patients, educators need to consider ways whereby they can motivate institutions and professionals to ensure that consistent care is provided to all patients.

—Contributed by Jocelyn Lockyer, University of Calgary

Research Book *Continued from page 4A*

Data Quality in Longitudinal Research focuses attention on issues that affect the integrity of longitudinal data and research, and does so in a manner that is easily understood, regardless of the level of sophistication of the reader. This volume is an important and welcome addition to the literature.

—Contributed by Deborah Jones and John Engel, Jefferson Medical College

Task Force *Continued from page 4*

pharmaceutical company. The PMA would similarly be encouraged to contact ACCME if an accredited provider was suspected to be in violation of the Guidelines.

4. There was agreement that ACCME should explore the use of an official "logo" by accredited sponsors. Use of such a logo would quickly indicate to the intended physician audience that a program was sponsored by an accredited sponsor obligated to abide by ACCME's "Guidelines for Commercial Support of CME."

5. A subcommittee was appointed to outline plans for a follow-up conference in 1991 to publicize and elaborate on the guidelines, including discussion of compliance and related issues. Judith Ribble will chair this committee composed of Tom Beckett and Bob Kristofco.

6. The Task Force should not plan to disband at this point, since the group is unique in its constituency and can serve a valuable on-going purpose for some time.

7. The Chairman was instructed to transmit to ACCME a request for the Executive or Planning, Educational Policy and Procedures committees to study the issue of making the "Guidelines for Commercial Support" either part of an existing Essential or a new Essential. ACCME would also be asked to consider the possibility of an industry seat or seats, either formally or in an observer capacity.

CANADIAN AND U.S. ORGANIZATIONS COLLABORATE FOR CME RESEARCH...

Two meetings this summer will be devoted to CME research resulting from cooperation by the American Medical Association and the Canadian Medical Association.

A jointly sponsored Institute for New Research Investigators in CME has been scheduled at the Westin Hotel, Vail, Colorado, August 1-3.

This exciting, first-of-its-kind conference is open to anyone with an interest in developing CME research skills and becoming updated on the discipline of research. Participants will be expected to present a potential research idea or project for constructive suggestions by the faculty. The meeting announcement will be distributed to registrants at the SMCDCME meeting in Toronto and mailed to other CME professionals in the U.S. and Canada.

Preceding the meeting for newcomers to the field will be an invitational "Consensus Building Workshop for CME Research" to be held at the Camberley Club Hotel, Beaver Creek, Colorado, July 27-30. Seasoned researchers wishing to receive an invitation to this meeting should submit a curriculum vitae and copies of published CME papers to Dennis Wentz, M.D., Director of CME, American Medical Association, 515 North State Street, Chicago 60610 or to Alexandra Harrison, Director, Educational Services, Canadian Medical Association, P.O. Box/C.P. 8650, 1867 Alta Vista, Ottawa, Canada, KIG 0G8.

Planning for both the above meetings have been coordinated by Robert Fox and David Davis.

Computer Corner:

dBASE IV in the CME Office

By S. Tunde Gondocz and Andrew Lai
Office of CME, University of Calgary

The usefulness and popularity of many commercial database management packages results from their ability to allow storage and rapid selective retrieval of information for many users with differing needs. In the CME office, dBASE IV, produced by Ashton-Tate Corporation, can be modified to handle the registration system, produce mailing labels for drug companies, and summarize and store course evaluation results.

One unique use for dBASE IV is storing and sorting qualitative data for needs assessment. In addition to course evaluation, the University of Calgary uses questions retrieved from the Medical Information Service (MIS) to assist planning groups in developing CME activities for urban and rural physicians. The MIS is a literature-searching service that uses consultants to review all information retrieved. Physicians phone in non-urgent questions that arise from their daily practice. These questions are then stored, using dBASE IV. A simple example of a database is an address file which includes:

Name	Address	City	Province	Postal Code
Smith, J	1 Main St.	Calgary	AB	T2S OK9
Jones, M	2 Main St.	Calgary	AB	T2S OK9

Each line includes name and address information and is known as a record. Each record is made up of smaller units of information, called fields. In our example, "Smith, J" is the first field for record one. MIS questions are stored similarly with each question being given unique ID numbers. Common fields, such as the ID number, help link sub-databases. Our sub-databases include: registration address file, consultant address file, question information file (question, keyword used for search, articles retrieved), and consultant feedback file (review of articles and additional comments).

When information is stored properly, retrieving data is a quick and easy process. dBASE IV has a powerful and easy-to-use Query by Examples (QBE) method to select information from desired field(s) in the database. Using the view function of dBASE IV, the user tabs to the appropriate "field" column to indicate if a search is being done on that particular field or combination of fields. With a common field, such as ID number, more than one database can be searched simultaneously. Therefore, information stored in separate databases (or sub-databases) can be combined for a single search.

The main advantage for the user is that previous knowledge of database commands and programming is not required in storing and retrieving information or in producing reports. However, for more complex information handling and data querying, a programmer with expertise in data handling and database programming should be used.

PROGRAM

Annual Meeting, April 26-29, 1991
Toronto, Ontario, Canada

Friday, April 26

Noon-5:00 p.m. **Executive Committee Meeting**
Boardroom A

Registration Desk open
Second Floor

12:30-4:30 p.m. **Meeting time for all committees**
Detailed schedule will be sent to individual chairmen.

4:30-5:30 p.m. **Regional Meetings**

6:00-7:30 p.m. **Opening Reception**
CN Tower
Join your colleagues and their guests for a spectacular view of Toronto.

Optional Social Activity:

7:35 p.m. Toronto Blue Jays vs. Detroit Tigers
SkyDome

Saturday, April 27

8:00-12:00 noon Registration Desk open
Second Floor

8:00-8:45 a.m. Continental Breakfast
Garden Court

8:45 a.m. **Opening Comments and Welcome**—*Vanity A*

Representatives of Hosting Institutions:

J. Tenenbaum, University of Toronto

David Davis, McMaster University, President, SMCDCME:

James Leist, Bowman Gray School of Medicine, Wake Forest University

Overview of Conference by Program Chairman:
Paul Lambiase, University of Rochester

9:00 a.m. **Keynote Presentation: Research Perspectives on the Nature of Clinical Reasoning: Implications for Continuing Education**

Geoff Norman, Professor, Clinical Epidemiology & Biostatistics Chairman, Program for Educational Development, McMaster University

Saturday, April 27, continued

10:00 a.m. **Submitted Research Papers**

Break

11:00 a.m. **The Maintenance of Competence Project of the Royal College of Physicians and Surgeons of Canada**

Overview — *John Parboosingh, University of Calgary*

Opportunities for Research in CME — *Robert Fox, University of Oklahoma*

Physician Adoption of Innovation: A Research Methodology — *John Parboosingh*

12:00 noon Adjourn

Optional Social Activities:

1:00-5:00 p.m. McMaster Health Sciences Centre Tour

1:00-10:00 p.m. Niagara Falls Tour

Evening Free for Individual Plans

Sunday, April 28

7:30-8:30 a.m. Continental Breakfast
Garden Court

8:30-12:00 noon **Individual Leadership Practices: A Current Assessment and Plans for Personal Development**

12:00-2:30 p.m. **Luncheon sponsored by The Municipality of Metropolitan Toronto**

Society Business Meeting
Windsor Ballroom

2:30-5:00 p.m. **Individual Leadership Practices** (continued)

Evening Free

Monday, April 29

7:30-8:30 a.m. Continental Breakfast
Garden Court

8:30-11:30 a.m. **Retreat** — *Vanity A*

CONTINUING EDUCATION FOR THE CMEDUCATOR

By Richard F. Bakemeier,
University of Colorado

This issue of *Intercom* includes the inauguration of a new feature—a column on educational topics directed at the needs of those of us involved in continuing medical education.

Is there a need for such a column? You as an *Intercom* reader can help answer this question. After reading this column, contribute your thoughts about the possible topics listed below—and about other education topics not mentioned—on which you would like discussions or references in forthcoming issues. In keeping with the Essentials, a Needs Assessment is in order here. Let's not use up valuable space in *Intercom* with material that is not of widespread interest to the readership.

Some suggested topics that might merit commentary and sources of additional information fall under the following headings:

I. CME METHODS
- A. *Course processes*
  - Conforming with principles of adult education
  - Teleconferences
  - Use of audiovisual assets, computers
- B. *Self-education*
  - Computer-assisted instruction
  - Enduring materials
- C. *Course management*
  - Negotiations
  - Brochure design and production
  - Marketing
  - Evaluation methods
- D. *Faculty Education*
  - In educational methods
  - In course planning
  - In course management
- E. *Staff Education*
  - Ongoing staff seminars; reviews

II. CME CONTENT
- A. *Staff awareness of advances in:*
  - Basic science
  - Clinical disciplines
  - Practice management
  - Medical ethics

III. OTHER (please specify)

Please number your five top choices by putting the numbers 1 through 5 in the appropriate spaces in front of the items. Then duplicate this column and send it back to:

Richard F. Bakemeier, MD
Office of CME, Box C295
University of Colorado HSC
4200 E. 9th Avenue
Denver, CO 80262

On the basis of your suggestions, I shall next time provide you some objectives for this column, and either an invited guest expert or I, will provide comments and references on one of the topics of your choice. We shall try to avoid duplication of subjects covered by other Associate Editors in their columns (Research, Computers, etc.) If you provide us with some comments in letter form, we shall try to include them as space permits.

Please do your part in making this section of *Intercom* particularly useful and interesting by participating in the formative stages of this idea.

POSITION ANNOUNCEMENT

Editor, Journal of Continuing Education in the Health Profession

The Alliance for Continuing Medical Education (ACME) and the Society of Medical College Directors of Continuing Medical Education (SMCDCME) are searching for an Editor for the *Journal of Continuing Education in the Health Profession.*

The top candidate will have significant experience (preferably with a research focus) in continuing education in the health profession, a commitment to scholarly work and the motivation to develop a quality publication. Factors to be weighed in the decision of suitable candidates will include experience on the editorial board of related publications and support from the candidate's institution, if applicable.

Characteristics of the Position

1. Produce four issues annually
2. Work with Managing Editor/Business Office based at University of California-San Francisco
3. Financial and business responsibilities limited to the development and oversight of a reasonable cost-recovery plan
4. Non-salaried position (Reimbursement for expenses only)
5. Initial appointment for 3 years. Renewal negotiable after review.

Applications/Nominations Due By: April 15, 1991.

Send Applications to:

Nancy Bennett, Ph.D.
Chairman, Search Committee
Department of Continuing Education
Harvard Medical School
25 Shattuck Street
Boston, MA 02115

The Search Committee will identify suitable candidates and recommend the best two choices to the President of ACME and SMCDCME for final selection no later than June 15, 1991.

Core Curriculum on Tuberculosis Available From The Centers for Disease Control

A training document on tuberculosis is now available from the Centers for Disease Control (CDC). The document was developed as part of the National Tuberculosis Training Initiative (NTTI) that was organized in 1989 by the American Thoracic Society, the medical section of the American Lung Association, and the CDC Division of Tuberculosis Control, for more than 22 national professional, medical, and nursing organizations. Robert J. Cullen represented SMCDCME in an NTTI conference in San Antonio in March, 1989 where training needs in tuberculosis for health care providers were identified.

The *Core Curriculum on Tuberculosis* contains information on epidemiology, transmission and pathogenesis, screening and prevention, diagnosis and treatment, infection control, and public health aspects of tuberculosis. It is intended for use in developing educational programs (e.g. seminars, grand rounds) as well as serving as a reference manual for health care providers caring for individuals with clinically active tuberculosis and tuberculosis infection.

A slide series has been developed to accompany the *Core Curriculum*. It may be obtained on loan (and duplicated) from your state tuberculosis control program.

Copies of the *Core Curriculum* may be obtained by writing to: Ms. Landis Brown, Technical Information Services, Center for Prevention Services, Centers for Disease Control, Mailstop E-06, Atlanta, GA 30333, telephone 404/639-1819. Please identify yourself as a member of SMCDCME.

Take Identification With You to Toronto

Even though the Gulf War has ended, immigration officials at US/Canadian borders may still be exercising tighter controls and stricter enforcement of immigration requirements. Canadian bound travelers may be required to show proof of citizenship such as a valid (or expired) passport, original birth certificate, or voter registration card.

The name on your airline ticket must match the name as it appears on your proof of citizenship. To avoid delays or problems, please be sure you have the appropriate, up-to-date identification and proof of citizenship before you begin your travel.

Other security measures that were in effect during the Middle East crisis included the following:

- No luggage was checked-in at curbside nor at ticket offices or other remote check-in locations, such as car rental locations.
- No one other than passengers holding tickets were allowed in the gate area.
- No unattended cars could be left within 100 feet of the airport terminal.

Relaxation of these regulations may occur in some localities but not in others. Therefore it would be wise to check with your airport or travel agent before leaving home.

Here are a few general suggestions to help make your air travel easier:

- Allow yourself extra time for check-in and security clearance.
- Keep your baggage with you, in sight, at all times.
- Do not accept packages from anyone, including friends and relatives.
- If you carry a computer, camera, or tape recorder plan to allow extra time, as security may wish for you to show how it works.

SOCIETY OF MEDICAL COLLEGE DIRECTORS OF CONTINUING MEDICAL EDUCATION
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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.