INTERCOM

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

Volume 5, Number 4 October, 1991

Fall Meeting To Feature In-Depth Discussion of Ethical Questions

By Paul Lambiase, Program Chairman

As announced earlier, the over-all focus of the Fall Meeting will be on "Ethical Issues and Conflicts of Interest." The hope is to raise issues, identify questions, explore parameters, and perhaps lay some groundwork that would help us understand how to use ethics to guide in the development of policy. Medical schools throughout the U.S. and Canada are faced with the challenge to develop policy and to implement procedures that will help insure that CME activities are appropriately screened, professionally organized and educationally motivated. The Program Committee hopes that the sessions this fall will help us to accomplish those objectives.

Saturday, November 9: Opening Session: 1:00 to 4:30 p.m.

The objective for this session, entitled "Ethics, Conflict and CME," is to identify and explore issues appropriate for a policy on conflict of interest in continuing medical education. The program will open with an introduction and overview of the topic followed by a presentation from a representative of the Food and Drug Administration giving its philosophy and providing a sense of what we might anticipate in terms of policy or guidelines in the coming months. A series of scenarios will then be presented. These will reflect issues that cause many of us some degree of concern, and do not lend themselves to easy answers. A keynote presentation will be given by Dr. John Fletcher, a biomedical ethicist who will attempt to draw conclusions from the situations discussed. There will be a review of the ethical principles involved and a look at the various problems from several perspectives. If time permits, questions will be taken from the audience.

Sunday morning, November 10: 9:00 a.m. to 12:00 noon

The research portion of the program will focus on issues arising from the Consensus Conference on Research, held this past summer. A series of brief presentations will be made on such aspects as: self-directed learning; the impact of formal education; and, adoption of innovation. There will be discussion devoted to defining how research results can be related to actual practice.

Continued on page 7

Keynote Speaker in November

John C. Fletcher, Ph.D. has been Professor of Biomedical Ethics and Religious Studies at the University of Virginia since 1987. In 1988 he also became Director of the Center for Biomedical Ethics, an activity of that institution's Health Sciences Center.

In 1956 Dr. Fletcher earned a Master of Divinity (cum laude) from the Virginia Theological Seminary in Alexandria and the following year received a Fulbright scholarship at the University of Heidelberg.

After two assignments as a parish minister, he pursued graduate study in Christian ethics at Union Theological Seminary in New York (1964-66). Then he joined the faculty of the Virginia Theological Seminary, where he worked with seminarians in the Urban Training Program and in an intern program in politics, urban affairs, and science/technology.

Dr. Fletcher came to his present position from the Clinical Center of the National Institutes of Health where he served for ten years (1977-87) as Chief of the Bioethics Program.

In 1985 the Clinical Center co-hosted the first national meeting of health care ethics consultants. Subsequently he was involved in founding the Society for Bioethics Consultation and was elected as its first President. Currently he serves as the association's Treasurer and member of the Board of Directors.

His research interest since 1985 has focused on approaches to ethical problems in medical genetics. He has published more than 150 articles or book chapters on subjects in biomedical ethics.

Dr. Fletcher is the Hospital Ethicist on the clinical staff of the University of Virginia Hospital and is a member of its committees on Hospital Ethics, Human Investigation, and Research Ethics. In addition, he serves on the Editorial Boards of four journals: *Bioethics, Human Gene Therapy, Journal of Clinical Ethics,* and *Fetal Diagnosis and Therapy.*

President's Comments

THE PRESIDENT'S COMMENTS for this issue are being prepared in mid-August. To me, summer is a time to combine a more informal lifestyle with the goals of closing the books on the past year's activities, completing annual reports, preparing for the coming academic year, and hopefully taking some vacation. Many of us approach summer with certain expectations for accomplishing a variety of tasks, but experience continues to show it's not easy to meet these expectations!

Society communications in particular are often delayed because of the varying vacation dates of officers and chairmen. Fortunately, however, the world keeps on turning during times like these. Reality and a sense of urgency suddenly seize us about a week before the arrival of the entering medical students, and suddenly we're off and running again.

Here are a few developments I wish to report to you.

1. I have appointed Past President Bob Cullen to a two-year term as our representative to the Council of Academic Societies. His new term of office will be July 1, 1991 through June 30, 1993. Bob has been one of our Society's representatives this past year, and he has been very effective in his work with the C.A.S. I might add that Lou Kettle of the AAMC staff strongly endorsed this appointment. Our other representative is Past President Dale Dauphinee.

Also, regarding the C.A.S. representatives, I've asked Bill Gust, Bylaws Chairman, to consult with his committee about the possibility of changing the selection of C.A.S. representatives from appointment by the Society President to election by the membership. My reasoning is that these positions are extremely important, and with staggered terms, there would be continuity and the membership would be empowered to influence the selection of these positions. I anticipate a report from Bill and his committee at the Fall Meeting.

2. It has been brought to my attention that adequate meeting space and duplicate registration fees are a problem at the Fall Meeting, which, as you know, takes place in conjunction with the AAMC meeting. A number of Society members want to attend only our sessions, but at present they are forced to pay the AAMC registration fee (currently $175) if they want a room at the headquarters hotel or near by.

Because of the size and complexity of the event, meeting space at the headquarters hotel is at a premium. One suggestion is to schedule our meeting at a different hotel immediately before the opening of the AAMC meeting. This would enable us to have adequate space for all the simultaneous committee meetings and to have our plenary sessions set up more comfortably in schoolroom style. If this idea were to be adopted, it would not be necessary for our members to pay the AAMC registration fee unless they wanted to request a room through AAMC and remain for that meeting.

I've asked Paul Lambiase, Program Chairman, and his group to consider this situation and make a report at the Fall Meeting.

3. During a discussion with Paul Mazmanian after the Toronto meeting, an idea emerged that would involve changing the structure of our meetings. Paul's point was that our members are becoming continually more involved in activities and projects, and meeting time at our bi-annual gatherings has become increasingly valuable for the purpose of accomplishing needed business. As a result, I've asked the Program Committee to consider allocating a larger proportion of time at future meetings for committee working sessions and less time to formal programming. Again, we can look forward to a report in November.

4. At the Toronto meeting, the Executive Committee heard from Vic Marrow and his committee on the development of a position paper entitled, "The Role of CME in Academic Medical Centers." The Executive Committee also heard a proposal from a group represented by George Smith to conduct a "Flexner-like" study of the state of CME in medical schools in the United States and Canada.

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Jocelyn Lockyer, Research Notebook

During discussion of this proposal, the suggestion was made to identify it as an examination of the current state of academic CME from a GPEP perspective. This study would be performed by an outside group of consultants to provide a totally objective assessment and report. George and Dale Dauphinee are optimistic about obtaining external funding for the project. Because there could be overlap in the reports, I sent letters to both Vic and George, detailing the Executive Committee's specific understanding of each report to provide clarification. We can look forward to progress reports from them at the Fall Meeting.

5. In my last column, I openly recruited for someone to work with George Smith to update our Strategic Plan and extend it into the future. Again, we're looking for someone who has an interest and some experience in strategic planning to be Vice Chairman of this important committee. As yet, no one has volunteered or been nominated. Please come to the Fall Meeting prepared to volunteer or to recommend someone to George.

6. This is by no means a complete report on current Society activities but in this limited space, I have hoped to present a sampling to keep you interested and informed. I'm in the process of designing a procedure for committee reports for the business meeting that will maximally facilitate reporting on activities and yet will enable us to conduct all our affairs within the allocated time. Your support and cooperation from the committee chairs are essential to the realization of this goal.

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Before closing, I wish to acknowledge the retirement of Varner Johns. He was a member of our Society for many years and was responsible for the Audio-Digest Endowment which supports a featured speaker at our Spring Meeting. On behalf of all of us, I wish to thank Varner for his many contributions to CME and our Society and wish him the best during his retirement.

I hope your summer was both productive and at times relaxing. I look forward to seeing each of you and encourage you to participate in the affairs of our Society this fall.

Jack L. Mason

CALL FOR PAPERS, RICME V

April 8-12, 1992, Birmingham, Alabama

This is the first call for papers for the 1992 Research in Continuing Medical Education Conference. Work that is complete or in progress will be considered. Length of the presentations will be 15 to 30 minutes. Please submit a one-page abstract by February 7, 1992 to:

Nancy Bennett, Co-Chair, RICME V
Department of Continuing Education, Box 825
Harvard Medical School, Boston, MA 02117
Phone: (617) 732-1568; FAX: (617) 732-1562

Those invited to present a paper will be asked to submit a 3-page summary for inclusion in a syllabus for the meeting.

COMPUTER CORNER

By Linda M. Saunders,
Division of Continuing Education,
Bowman Gray School of Medicine

K/M Registrar+ is a software package designed to aid educational institutions with registration and meeting management. The package consists of a base module for registration applications, plus expansion modules for third-party billing and the reporting of faculty participation and income/expense.

The base module produces a multitude of reports, such as activity options, mailing labels (pressure-sensitive or Cheshire), course/activity roster, course/activity contact list, name tags, attendance certificates, postcards, transcripts, receipts, invoices, statements, master-balance-due report, course-activity fee summary and multi-course summary.

K/M Data Systems, Inc., the developer, selected Bowman Gray School of Medicine as a test site in 1985 and installed the system in our Division of Continuing Education (DCE) as well as our Area Health Education Center (AHEC) Program. The DCE currently has a data base of 394 programs and 10,973 participants.

To set up a new program file, a unique identifying key consisting of nine characters (numerical, alphabetical or a combination) must be assigned. An identifying code (Social Security number) for each registrant is also required. Participants need be entered only one time and then retrieved by their identifying code when they attend another program, thus enabling quick and easy registration for repeat participants. Program files are purged annually and extraneous information deleted. Crucial participant information such as Social Security number, address, phone, program attendance and so on, is maintained.

K/M Registrar+ does not require a graduate in computer science to load or to operate. We have found it to be a very user-friendly system. After the initial installation and training in 1985, our staff has trained each new operator as needed. Explicit instructions are provided with each update; therefore further training from the developer has not been necessary. If questions arise, K/M Data Systems, Inc. will provide consultation and technical support (8:00 a.m.-10:00 p.m. EST). More importantly, the developers will modify the system to suit whatever specifications you may have for your organization. For example, we just received a module for Grand Rounds modified to our needs.

In summary, K/M Registrar+ has proven to be a cost-effective, extremely user-friendly system. K/M Data Systems works well with us in responding to our needs. The system is well worth the time and effort to review if you are in the market for registration management software.

For further information, call the distributor, LERN, at 1-800/678-5376.

TASK FORCE ON PHARMACEUTICAL INDUSTRY-CME PROVIDER COLLABORATION

By Robert J. Cullen, Vice-Chairman

When the revised Guidelines for Commercial Support of CME were approved by the Accreditation Council on March 15, this approval indicated that the major charge to the Task Force had been accomplished. However, that would only be telling you the end of the story. Since this was a major milestone for CME and for the Society, I think more should be said.

Clearly this outcome could not have been attained without the collaboration of many organizations *and* without considerable work prior to the formation of the Task Force. I think it is important to recognize that the Society played a key role in this effort from the beginning to the end. Our Committee on Cooperation with Industry, chaired by Martin Shickman, was instrumental in conceptualization and planning, as well as development and implementation of the major meetings which brought together leaders from CME and the pharmaceutical industry to develop mutually beneficial cooperative relationships. I believe the committee met its charge by serving as a catalyst for action.

The first meeting influenced by the Committee was hosted by Marion Merrell Dow in Scottsdale in December, 1989. This meeting brought together CME leaders from medical schools, Marion Merrell Dow and government agencies to look at ethical issues relating to commercial support for CME. It was directed by Martin Shickman, Joseph D'Angelo and Lee Yerkes. This conference not only developed an awareness of the issues, it set the stage for subsequent action.

A highlight of the 1990 National CME Congress was the session on Cooperation with Industry, which was planned and conducted by some of our committee members. The cornerstone of that session was the presentation given by David Banks of the Food and Drug Administration, which clarified for the first time the agency's major concerns about commercial support of continuing medical education.

The clearly stated intentions of the Food and Drug Administration *and* some Congressional committees to become involved in discussion of commercially supported CME provided the momentum needed to bring together key players to define the problems and bring about change. The Invitational Conference in Chicago sponsored by the AMA, AAMC and the Society in August 1990 provided a forum for deliberating and understanding the issues. The 135 attendees at this meeting represented at least 26 pharmaceutical firms, 17 medical schools and 30 professional organizations.

The Task Force on Pharmaceutical Industry-CME Provider Collaboration was born at this conference. Members of the Society's Committee on Cooperation with Industry formed the core of the Task Force.

Over the next several months, the Task Force met several times by phone or in person to produce a new set of Guidelines. An ongoing dialogue between the Task Force and ACCME, facilitated by Richard Wilbur of ACCME and Dennis Wentz, Chairman of the Task Force, led to rapid action and approval of the Guidelines.

I should also point out that concurrently the AMA produced an ethics statement on "Gifts to Physicians from Industry" and the Pharmaceutical Manufacturers Association adopted a new Code of Pharmaceutical Marketing Practices. It was no accident that sections of the three documents were almost identical.

The synergism produced by the overlapping membership and effective communication among the various groups involved created uniformity of thought and action.

What's next? Is the Task Force finished? Well, not quite yet. A follow-up conference (see next page) October 8-10 will focus on the Guidelines with an emphasis on education and compliance. Further education may be developed for the 1992 National Congress.

One of the Guidelines requires development of policy on conflict of interest. Here, too, the Society is providing leadership. At the request of James Leist, Van Harrison has developed an excellent working paper to aid in the development of such policy. Furthermore, the Council of Academic Societies of AAMC, in response to a request from the SMCDCME, will consider the role of medical school faculty in CME and examine conflict-of-interest issues.

In summary, the collaboration of CME providers and the pharmaceutical industry as exemplified by the Task Force has resulted in new guidelines for commercial support of CME. Our Society has played a major role in this accomplishment.

RESEARCH NOTEBOOK*

ARTICLES WORTH READING

Qualitative Research

A number of qualitative research studies have been published recently which add new dimensions to our understanding in the field of CME.

Stein HF, *The Role of Some Nonbiomedical Parameters in Clinical Decision Making: An Ethnographic Approach.* Qualitative Health Research 1991, 1(1):6-26.

Stein advocates the ethnographic method as a means of eliciting biomedical decision making. The article presents several clinical decision-making vignettes to illustrate the complex texture of medical thought and action.

Obershoff JA, Forsyte DE, Buchanan BG, Bankowitz RA, Blumenfield BH and Miller RA, *Physicians' Information Needs: Analysis of Questions Posed During Clinical Teaching.* Annals of Internal Medicine, 1991, 114(7): 576-581.

In this study, an anthropologist observed communication among physicians and medical students and recorded expressions of need for information. The requests were coded. They found that five clinical questions were raised for each patient discussed, with the majority relating to patient care. Over half were requests for information available in the medical record. About one quarter of the questions required a synthesis of patient information and medical knowledge.

Report of the CME Research Consensus-Building Workshop

A critical review of the state of the art of CME research took place in Beaver Creek, Colorado, July 28-30, 1991. The invitational meeting, sponsored by the American and Canadian Medical Associations, was attended by 31 university faculty members, journal editors, and representatives from organized medicine. Through focused, small-group discussion, hundreds of CME publications (research, literature reviews, and editorials) were examined, interpreted, and synthesized in an effort to describe the state of the art of CME research and identify future directions for CME research and practice.

Each of the three days had a different theme. The first day was devoted to the CME enterprise and the culture of health care. Participants examined such issues as differences between CME providers, the effectiveness of formal and planned individualized CME activities, factors affecting physician attendance at formal CME programs, and the effect of the practice environment on physician learning.

Physicians as learners was the second theme. The focus was on factors motivating physicians to do self-directed learning, characteristics of physicians' self-directed learning, how physicians adopt innovations, the effect of age and stage of professional development on learning, and how physicians learn from clinical encounters.

Assessment and evaluation was the final theme. Groups looked at the effectiveness of chart audits, standardized patients, and objective structured clinical examinations for assessment and evaluation purposes as well as the identification of incompetent physicians.

Over the next several months, the groups will continue to review the literature and prepare manuscripts for publication. Both the 1991 Fall Meeting of the Society and the 1992 National CME Congress will disseminate information resulting from the workshop.

—Jocelyn Lockyer,
University of Calgary

"Developing Research in CME"

Summary of An Institute for New Investigators

This 2½ day workshop, sponsored by the American and Canadian Medical Associations, brought sixteen "new" investigators to Vail, Colorado, August 1-3, 1991.

The major objective of the conference was to help individuals develop a research question in CME into a more fully evolved research proposal. Participants were assisted in this process by a mixture of large and small group sessions and individual consultation with faculty members* in a variety of subject areas. The topics included: theoretical constructs relevant to CME research; reflection in action as learning theory, qualitative and quantitative research methods; literature-search strategies relevant to CME; and problem-based learning.

By an interactive, iteractive process, participants were able to incorporate theoretical and methodologic principles into their own study designs and to present their research proposals to the group at the conclusion of the conference.

Future plans include post-institute questionnaires at roughly six-month intervals to determine the status of the specific reserach proposal and to elicit further comments from participants regarding the nature of the institute and its value.

*Drs. R.D. Fox, K.V. Mann, P.E. Maxmanian, J. Parboosingh, D.A. Davis. Non-participating faculty included Dr. Nancy Bennett, Mrs. Alexandra Harrison and Dr. Dennis Wentz.

—David A. Davis, McMaster University

Continued on page 5-A

***Material Coordinated by Jocelyn Lockyer**

BOOK REVIEW

Case Study Research in Education, A Qualitative Approach. Sharan B. Merriam. San Francisco: Jossey Bass Publishers, 1988.

For those who view CME as a complex, problem-centered process, *Case Study Research in Education* is a welcome addition to the research methodology bookshelf. Case study research has been used extensively in the professions to study the processes of practice, and is particularly useful because it facilitates discovery, understanding, and insight.

In this volume, Merriam, Professor of Adult and Continuing Education at the University of Georgia, brings together useful and practical information from a variety of sources to provide a complete treatment of case study research (CSR).

Part I presents the conceptual basics of CSR, defines what it is as well as what it isn't; describes appropriate uses, strengths, weaknesses, and limitations of the methodology; and discusses special characteristics that the researcher must possess to conduct case study research (sensitivity, tolerance of ambiguity, and communication skills). Practical considerations also covered in Part I include (1) how to formulate and focus research problems and (2) questions regarding the roles of theory and literature in shaping and informing the research process.

Merriam describes CSR as a form of systematic inquiry which focuses on a specific bounded situation, event, or phenomenon. The purpose of CSR is to provide understanding via description, and it relies heavily on inductive reasoning. Merriam focuses primarily on qualitative CSR in education, and describes different types of CSR (ethnographic, psychological, sociological, and historical) as well as different types of outcomes (descriptive, interpretive, evaluative, and exploratory).

In Part II, Merriam discusses in depth three major sources of data for CSR: interviews, observation, and documents. She covers practical issues related to each technique and provides checklists, guidelines, and "how to's" of things such as sample identification, asking good questions, recording data, what to observe, and finding relevant materials.

Part III is devoted to the analysis and reporting of data. In qualitative research, data collection and analysis are simultaneous activities that constitute an interactive process. Merriam makes practical suggestions for analysis during data collection, for making sense of data, for developing categories, and for coding data. She discusses technical aspects of different ways to manage data, and discusses strengths and weaknesses of various computer software packages.

The author addresses issues of reliability and validity as they relate to qualitative research in general and to CSR specifically. She offers strategies for assuring and improving internal and external validity, and discusses reliability in terms of consistency and dependability of the results. Potential ethical problems in CSR are discussed. Finally, a chapter is devoted to the process of report writing.

Case Study Research in Education is a well-organized book which provides a sound and practical source of information for the researcher considering the method. Examples, guidelines, and references are excellent.

—Deborah L. Jones,
Jefferson Medical College

A Research Technique to Consider: Case Studies

Patient cases form the basis of medical practice. These cases, individually and collectively, provide a rich source of data about how physicians practice. Chart audits, observations of physicians providing care, and interviews or questionnaires with physicians about specific cases have all been used successfully to learn more about the practice of medicine.

More recently, a combination of two of these techniques—chart audits and interviews—has been used to determine how physicians work, solve problems, make decisions, and render services that are not recorded. The interview mitigates the shortcomings of chart audit, namely, that actions are inconsistently recorded and do not provide a rationale for actions taken. Chart-stimulated recall and case-recall interviews are terms that have been used to describe the technique. Generally, the interviews are designed in a structured or semi-structured way to ask a series of questions related to the case as it unfolded naturally. Subjects normally have access to their charts during the interview. By using careful intentional questions and skillful probing to gather desired information, the interviewer controls the pacing and content of the interview.

For the CME office, case study research could be used to identify common learning needs, develop cases for CME presentations, determine physician perception and understanding of new standards, and evaluate the results of educational interventions.

(1) Lockyer JM et al, "Stimulated Case Recall Interviews Applied to a National Protocol for Hyperbilirubinemia," *Journal of Continuing Education in the Health Professions,* 1991, 11(2):129-137.

(2) Reinhart MA et al, "Designing a Reliable and Valid Chart Stimulated Recall Examination," *Proceedings of the Annual Meeting of the Society of Academic Emergency Medicine,* May 1990.

(3) Solomon DJ et al, "An Assessment of an Oral Examination Format for Evaluating Clinical Competence in Emergency Medicine," *Academic Medicine,* 1990 (September Supplement) 65(9):S43-S44.

—Jocelyn Lockyer,
University of Calgary

Evaluation of Industry/CME Provider Relationships Slated for October 8-10

Are the Guidelines for collaboration between industry and CME providers clearly understood? Are there new interpretations? Is compliance with the Guidelines spotty or widespread? What does the Food and Drug Administration think of the current situation?

These and related questions are the basis for convening the Second National Conference on Collaboration Between Industry and CME Providers, which is scheduled for October 8-10 at the Drake Hotel in Chicago. Invitations have been extended to representatives of CME providers and 120 commercial companies.

Utilizing the theme, "Relationships in Transition," the meeting will focus on changes occurring since August 1990 when the first conference was held. This time non-pharmaceutical representatives will join those from the pharmaceutical industry in the discussions with CME providers as they seek to shed light on current interpretations of the Guidelines, and the resulting degrees of compliance.

Sponsors of the conference are: Accreditation Council for CME, Alliance for Continuing Medical Education, American Academy of Family Physicians, American College of Cardiology, American College of Physicians, American Medical Association, Association of American Medical Colleges, Council of Medical Specialty Societies, Health Industry Manufacturers Association, Pharmaceutical Manufacturers Association, and the Society of Medical College Directors of CME. Arrangements are being coordinated by AMA's Division of Continuing Education which is headed by Dennis Wentz, Chairman of the Task Force.

A special pre-conference workshop on Tuesday, October 8, will examine the standards for accreditation of CME providers and their responsibilities in accepting program support from commercial companies.

On Wednesday morning, October 9, James Todd, Executive Vice President, American Medical Association, will welcome participants and highlight the need for discussion. Speakers at the first half of the session will include Douglas Watson, President, Pharmaceuticals Division, Ciba-Geigy Corporation; Martin Shickman, Associate Dean for CME, University of California at Los Angeles; and Kirk Johnson, General Counsel and Senior Vice President, American Medical Association. Richard Wilbur, Executive Secretary, Accreditation Council for CME, will answer questions about the Guidelines promulgated by the Council.

After the morning break, three representatives from the Food and Drug Administration will offer "Perspectives on Medical Communication." Scheduled panelists are Ann Witt, Acting Director; Peter Rheinstein, Director, Medical Staff Office of Health Affairs; and Steven Niedelman, Deputy Director, Division of Compliance Operations Center for Devices and Radiological Health. Then commercial perspectives will be provided by Glenn Nelson, Vice-Chairman, Medtronics, Inc., representing the non-pharmaceutical industry, and an invited representative of the Pharmaceutical Manufacturers Association.

Following lunch, conflicts of interest will be addressed by three representatives of CME providers: Louis Kettel, Vice President, AAMC's Department of Academic Affairs; Daniel Ostergaard, Vice President, Department of Educational and Scientific Affairs, American Academy of Family Physicians; and Robert Cullen, Executive Director, Regional Medical Education Council, Veterans Administration.

The remainder of the afternoon will be devoted to discussion of whether the Guidelines are affecting medical practice and, if so, in what ways. After a half-hour general session, participants will break up into small groups, with leaders receiving their charge from Dr. Cullen and Robert Orsetti, Executive Director, Medical Education and Communications, Ciba-Geigy Corporation.

Final topic on Thursday morning, October 10, will be "Education vs. Promotion: A Need for Clarity," presented by Frank Davidoff, Assistant Executive Vice President for Education, American College of Physicians. Then James Leist, Bowman Gray School of Medicine, will preside as the small group discussions are summarized.

◄◄ EXECUTIVE COMMITTEE POSES AT SPRING MEETING

Back Row, l to r: James Leist, Immediate Past President; William Gust, Midwestern Region; Van Harrison, Second Vice President; Robert Kristofco, Secretary-Treasurer; and Martin Kantrowitz, First Vice President. *First row, l to r:* Rosalie Lammle, Western Region; Jack Mason, President; and Grace Wagner, Southern Region. *Not Shown:* Karen Mann, Northeastern Region, who was unable to attend the Toronto Session.

RETREAT REPORT

By Susan P. Duncan, M.Ed., CME Director
Univ. of Texas Health Science Center, San Antonio

The 1991 SMCDCME Spring Retreat in Toronto, moderated by Deborah Holmes, Dartmouth Hitchcock Medical Center, offered an opportunity for members to share ideas, concerns, questions, and answers. At a point early in the retreat, a suggestion was made that members who were unable to attend should be informed of some of the topics discussed. Hence, this summary report.

Early discussions concerned new Category 2 requirements and what, if any, will be the responsibilities of accredited providers. Impressions were that it would be good to know how different schools choose to handle this.

The increase in Society dues was discussed, and a question raised as to whether there should be a much larger increase of dues in the future in order to support a permanent staff and increase Society activities. Schools' annual membership fees for the AAMC were used as an example. Observations included these:

1. "A few years ago we were talking about survival; . . . now we're talking about full-time staff and quadrupling income. Obviously, the Society cannot survive on dues alone."

2. "What better place for pharmaceutical companies to put $5 to $10,000 with no strings attached?"

It was noted that it would be helpful to have copies of Society Bylaws available at the Retreat.

Attendees were asked about cutbacks within their universities and how they are impacting on continuing education. Some possible results noted were that CME would not have as high a priority when faculty members must scramble for funds, or that budget cuts may actually make CME offices busier as research monies are cut. The institutions may see CME as another means of public relations and of generating money and patient referrals to "make up the slack."

The moderator asked if anyone had actual paper proof that CME brings in referrals. Several members responded that they did. One method of tracking mentioned was the use of a toll-free number. The strength of this method is that the marketing department, which controls the toll-free number, gets bonuses based on productivity. Other ideas noted were (1) a requirement for tracking which physicians refer*, or (2) when a patient is checked in, stamping the referring physician's name on all paperwork. Possible complications were noted, such as the partner who had attended the CME activity having an influence on referring the patient with his partner who did not attend.

A question asked of those who were in states with more than one medical school, was: "How do you cooperate with other institutions in CME, and CME research versus turf?" Members listed these: working on certain courses together, some sharing, division of territory, and the difficulty of devoting time and energy to efforts that are not going to bring financial returns.

Members were asked "What companies are hassling you?" An experience with a well-known company's lipid programs promoting a particular product was shared, noting that it is easy to *not* recognize this problem. One member noted that they only acknowledge companies' support on the brochure and allow *no* salesmanship. If the company does not comply, it is not invited back, or the institution does not accredit the program. All members agreed that companies must not dictate content. Most institutions indicated that they do not conduct programs that carry no registration fees (i.e., because the fees are covered by a pharmaceutical grant).

Another member noted that some companies had given money to their CME office; this can be used to cover costs of speakers and programs. These funds are not identified for specific speakers or programs; their use is at the discretion of the CME office.

There followed some discussion of honorarium amounts for faculty for a one-hour lecture. A range of $100 to $750 was cited among the schools represented.

It was suggested that pointing out to Deans and Department Chairmen the amount of money paid to an institution's own faculty through participation in CME activities might be a useful tool in indicating the positive role of CME for the school and faculty. Discussion of honoraria and compliance with new conflict-of-interest action included a suggestion that faculty members introduce themselves by saying, "I am being paid by (company name) to give this talk."

Some schools are planning to require that all honorarium payments go through their school accounting system. This is not, however, a requirement in the new guidelines. Some schools ask the pharmaceutical company to submit an itemized statement of what honoraria and expenses were provided.

Legal versus ethical issues were discussed in the biotech field context. Devices were noted as being different from pharmaceuticals in that there must be a fixed program with the best people to teach installation. First Vice-President Martin Krantowitz stressed that this was the time for the Society "to be pro-active, not re-active—but not naive."

Members were asked if anyone had ideas for ways to do things better, faster, and less expensively. Suggestions of this kind should be forwarded to *Intercom* for future inclusion in the newsletter. Ideas discussed at the retreat may serve to spark additional thoughts as well as to "fill in the spaces" for those members unable to attend the gathering.

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*R. Van Harrison et al *The Association Between Community Physicians' Attendance at a Medical Center's CME Courses and Their Patient Referrals to the Medical Center.* JCEHP 1990, Vol. 10, No. 4, pp. 315 through 320.

FALL 1991 PROGRAM *(Continued from p. 1)*

Saturday Afternoon, November 9, 1991
1:00 p.m. to 4:30 p.m.
"ETHICS, CONFLICT AND CME"

Opening/Welcome
Jack Mason, President, University of Maryland School of Medicine
Paul J. Lambiase, Program Chairman, University of Rochester School of Medicine & Dentistry

Introduction and Overview
Van Harrison, The University of Michigan

Videotape: Exposé on CME

Presentation by FDA Representative explaining the agency's philosophy and providing an overview of what we can anticipate in terms of guidelines or requirements

Scenarios (4 to 6)
Presenters: Martin Shickman, Director, Department of CME, UCLA School of Medicine and others to be identified

Scenarios should reflect situations that cause the most grief, are multi-faceted, and do not present easy black or white answers.

(20-minute break scheduled midway through scenarios)

Keynote Presentation
John C. Fletcher, Professor of Biomedical Ethics, School of Medicine, University of Virginia

The presentation will draw conclusions from the situations discussed, review the ethical principles involved, and examine problems from various perspectives.

Discussion and Questions from the audience

GEA/Small Group Discussion

Monday, November 11, 1991—2:45 to 4:15 p.m.
SESSION TITLE: New ACCME Accreditation Guidelines for Commercial Support of CME

This small group forum is intended to review the new guidelines for commercial support of CME. Need for the guidelines will be discussed, along with their acceptance by CME providers, the pharmaceutical industry and equipment manufacturers. The potential impact of these guidelines on CME operations will be explored.

Moderator: **Robert J. Cullen,** Executive Director, Regional Medical Education Council, Veterans Administration

Panel: **Dennis Wentz,** Director of CME, American Medical Association

Frances M. Maitland, Assistant Secretary, Accreditation Council for CME

David Lichtenauer, Medical Sciences Liaison, The Upjohn Company

Joint GEA/SMCDCME Plenary Session

Monday, November 11, 1991—6:30 to 8:00 p.m.
SESSION TITLE: Conflicting Interests: Commercial Support of Medical School Faculty in the CME Arena

This session will highlight selected issues presenting potential conflicts of interest for medical school faculty involved in CME activities. Both faculty and CME organizers have come under increasing pressure to develop and adhere to conflict of interest guidelines as they relate to public sector support of their activities.

While some situations might at first appear either appropriate or inappropriate, real-life situations are frequently somewhere in the middle. To make a decision requires not just the "simple" facts, but often an understanding of degree, intent, and some knowledge of the values or principles involved.

This session will pose a series of case examples taken from real experiences. Panelists will respond to each case, offering their individual perspectives. Topics will include such areas as: excessive honoraria or other perquisites; faculty speaking on behalf of personal research; situations defining degrees of disclosure; and others.

Moderator: **Phil R. Manning,** Associate Vice President, Health Affairs, University of Southern California

Panel: **Nancy W. Dickey,** Member, Board of Trustees, American Medical Association

William E. Easterling, Jr., Associate Dean for CME and Alumni Affairs, University of North Carolina at Chapel Hill

Robert Orsetti, Executive Director, Medical Education and Communications, Pharmaceuticals Division, Ciba-Geigy Corporation

Membership Directory Update

Page 6—Restore Ralph Hale's FAX number to 808/955-2174.

Page 8—Add Paul Lambiase's FAX number: 716/473-1482.

Page 9—Jocelyn Lockyer has a new title at the University of Calgary. She is now Director of CME.

Page 15-For Thomas Stair's listing, add "Office of Continuing Medical Education" under his name. Also add "Medical Center" after "Georgetown University," and change the address to 4000 Reservoir Road NW.

Critical Issues for Continuing Educators

In the Spring 1991 issue of *The Journal of Continuing Higher Education,* Robert G. Simerly wrote the lead article entitled "Preparing for the 21st Century: Ten Critical Issues for Continuing Educators." In that article, Simerly identified organizational and environmental issues, plus issues about the nature of continuing education itself. He noted action strategies for continuing educators on each of the issues listed below.

I. Organizational Issues With Action Strategies

A. Ambiguity in organizations will increase.
   1. Develop a wide repertory of conflict management skills.
   2. Identify windows of opportunity.
   3. Become skilled in the use of stratanomics. (Stratanomics is the area of organizational theory which describes how *leaders* create conditions for effective decision-making and strategy development.)

B. Organizational problems will become more complex, more global and more political.
   • Build strategic alliances.

C. Human resource development will play an expanded role in the organization.
   • Empower staff.

D. Increasingly, continuing education programming is becoming mainstreamed in our institutions.
   1. Participate in institution's faculty reward structure.
   2. Actively participate in helping the parent organization define its major agendas.

E. Individuals are responsible for actively creating their organization's value system that encourages ethical behavior.
   1. Identify and analyze the major types of value systems underlying our organization.
   2. Adopt the highest standards of ethical conduct.

F. Effectiveness in managing diversity is an important leadership skill.

II. Environmental Issues With Action Strategies

A. Everyone has discovered the "new majority."
   1. Develop innovative approaches for dealing with market segmentation.
   2. Develop a portion of your budget to testing new market strategies.

B. The work force will demand dynamic, action-oriented organizational cultures.
   1. Carefully plan for the type of organizational culture that will ensure personal and organizational success.
   2. Develop a comprehensive client service orientation.

III. Issues About the Nature of Continuing Education with Action Strategies

A. Continuing education is big business.
   1. Develop comprehensive strategic planning.
   2. Demonstrate return on investment.

B. There will be increased competition for scarce resources.
   1. Follow the four basic rules for success in financial management. (Learn your budget, learn your budget, learn your budget and learn how to manage your budget.)
   2. Develop sophisticated financial modeling.

These issues and the accompanying action strategies suggest a bright future for continuing higher education and, we believe, are germane to continuing medical education as well. The issues and action strategies point out the need for strong leadership (vision) and management in our profession. Simerly's article gives us significant provocation for our own continued leadership and management education.

Future articles in this newsletter will continue to present theoretical issues and practical tips for more effective leadership and management in CME administration.

—James C. Leist, Bowman Gray School of Medicine, and Robert C. Fore, Mercer University

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

Fall Meeting:

November 8-11, 1991
in conjunction with
the AAMC Annual Meeting
November 8 through November 14, Washington, D.C.

PLAN TO ATTEND!

Paul J. Lambiase
Director, Continuing Professional Education
Univ. of Rochester Sch. of Med. & Dent.
601 Elmwood Avenue, Box 677
Rochester NY 14642
V 104

REC'D OCT 8 1991

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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.