INTERCOM

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

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1995 Fall Meeting at The AAMC

October 28 - November 2, 1995
Washington, D.C.

Society Program
Saturday, October 28
Sunday, October 29
Monday, October 30

For more information
call or write Gloria Allington.

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The Society Mourns a Loss

Martin D. Shickman, M.D.

Martin D. Shickman, M.D., clinical professor of cardiology and assistant dean for postgraduate medical education at the UCLA School of Medicine, died April 20, 1995, of complications following cardiac surgery, at the age of 67.

Dr. Shickman had been an active member in the Society since 1973. Two weeks prior to his death he attended the Spring Society meeting in St. Louis, where he was elected vice-president of the Society. At that time he also was honored with the Distinguished Service Award of the Society in recognition of his outstanding contributions to continuing medical education over an extended period of time.

A noted expert in hypertension, Dr. Shickman became a leader in demonstrating the importance of continuing medical education in quality of patient care. He served as the director of the UCLA Extension department of continuing education in health sciences, and coordinator of the UCLA division of CME until 1994. Since 1994 he has been special consultant to the UCLA office of continuing medical education. Dr. Shickman also directed the UCLA components of the Central San Juaquin Valley Area Health Education Center, a joint venture between the UCLA and UCSF medical schools.

Dr. Shickman was past president and recipient of the Heart of Gold Award from the Los Angeles affiliate of the American Heart Association in 1986. He received the Louis B. Russell Jr. Memorial Award from the American Heart Association in 1980, and was the recipient of Distinguished Service Awards for Clinical Teaching from UCLA School of Medicine.

He is survived by his wife, Lois, and sons Steven, David, and Trevor. Those who wish to send Lois their condolences may direct them to: 235 South Bentley, Los Angeles, CA 90049.

President's Message

Gloria H. Allington, M.S.Ed.

In Recognition

We will miss Marty. The sudden passing of our vice president, Dr. Martin D. Shickman, was a shock to us all. A member of the Society since 1973, he served with well deserved distinction as chair of the committee on cooperation with industry and as the Society's representative to the task force on CME provider/ industry relations. Marty's extensive contributions to continuing medical education were recognized at the Spring meeting when he received the Distinguished Service Award of the Society. The Society has truly lost a valued colleague and friend, and sends its condolences to his family.

Overview of Goals

This year's goals attempt to respond to the serious and immediate issues facing the health industry. Such issues spawn challenges but provide opportunities as well. The former dictates that continuing medical education professionals increase their efforts in showing how they are a necessary component in the emerging new medical delivery system. Opportunities, on the other hand, abound to those in our society who have much to contribute to the solution.

The leadership theme might be best named "Validating CME in the Particular". Simply, the Society has a unique opportunity to prove its usefulness to its members as they must respond and work within their particular environment. Not every member institution has the same problems and challenges, but the membership as a whole have experiences with the processes and issues facing a particular member. By providing extensive and organized networking, information, and support, the Society can assist in allowing each CME unit to more effectively and profitably fit into the total health picture. The Society can assist members through increased networking of resources, talents, and skills, and by identifying and providing the expertise - both from Society members and from experts in other areas - that will provide the tools for members to become a key component to the changes taking place. Our membership contains noted experts in theory, practice, and foundations of knowledge used in the CME setting such as needs assessment, principles of adult learning, evaluation and assessment, research approaches and methodology. Additional key competencies and skills need to be provided for Society members, from resources within and outside the Society, as appropriate, to enable them to effectively meet the challenges and demands of the new environment - experts in areas such as managed care delivery systems, teambuilding, negotiation and conflict resolution, and management and leadership skills.

Our membership recognizes and espouses the importance of continuing medical education in attaining the initiatives of access and quality of care. Initiatives to demonstrate physician education as the key to meeting the challenges of this era must continue until principal representatives from medicine, government, and health care systems recognize and appreciate this necessity and acknowledge its value. Continuing medical education must be present at the table as a partner.

Three major goals have been established for the coming year: 1) enhancement and strengthening of relationships with principal associations and organizations influential to the educational continuum; 2) providing access, resources, and training for Society members to most effectively meet the evolving challenges; and 3) streamlining and consolidating the Society's organizational structure for maximum utilization of resources and expertise.

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Report from the Membership Committee

Marion C. Anderson, M.D.

The Society welcomed the following new members at the Spring meeting in St. Louis:

Barbara E. Barnes, M.D.	University of Pittsburgh (V)	Timothy R. Brigham, Ph.D.	Jefferson (V)
Deborah H. Brown	East Tennessee (V)	Arthur M. Freeman, M.D.	University of Alabama at Birmingham (A)
Dawn P. Hicks, M.D., Ph.D.	University of South Alabama (V)	Marcia J. Jackson, Ph.D.	American College of Cardiology
Alan B. Miller, M.D.	University of Florida at Jacksonville (V)	Richard J. Sperry, M.D., Ph.D.	University of Utah (V)
Claudia Stravato	Southwestern (V)		

(V) - Voting, (A) - Associate

Society membership stands at 257 (125 voting, 81 associate, 51 other) and 110 US and 12 Canadian medical schools are represented

Views From a New Member

John Windle, M.D.

In November, I was asked into the Dean's office for a meeting. His secretary stated only that I should know what this was about. I mentally reviewed all of my recent transgressions and prepared for my penance. After the usual pleasantries, Dean Maurer leaned towards me and handed me a manuscript entitled "Creating a New Paradigm for CME: Seizing Opportunities Within the Health Care Revolution" by Donald Moore, Joseph Green, Steven Jay, James Leist and Frances Maitland. He asked me to read it and return in a few days with my thoughts. After 15 years as associate dean for continuing medical education, Fred Paustian was retiring and I was chosen as his successor. From a background of clinical care for patients with cardiac arrhythmias, basic science research into the origin of cardiac arrhythmias, and student and resident education, I was asked to become assistant dean for continuing education at the University of Nebraska Medical Center.

My career and education in continuing education began in earnest in January. Marge Adey and Bill Gust welcomed me on board with a ticket to the Alliance meeting in Phoenix, a book by Robert Fox, Paul Mazmanian and R., Wayne Putnam, entitled "Changing and Learning in the Lives of Physicians" (two things I wasn't sure physicians wanted to do) and a list of people I should meet.

In April I attended my first "Society" meeting. Knowing few people I was impressed with the warmth and cordial nature of the group. Further, there was openness in the discussions without the appearance of battling that plagues many medical meetings. In particular, the discussion that followed Dr. Larsen's presentation about ethics in managed care was refreshing. The open lunch forum on computers in continuing education provided an opportunity to share and build on opportunities and experiences in innovative areas such as multimedia and telecommunications.

The Society's theme "Energizing for Change" was very much in evidence at this meeting. Perhaps the most important thing I brought back from the meeting was an understanding of the critical role that continuing education (that is continuous lifelong learning) plays in the transition of health care. The Society has not only the expertise but the mandate to lead the change in health care. Continuing education directors understand marketing, understand adult education and communications, and can apply this information in an ethical manner using the seven essentials. It is also apparent that we may need to apply our marketing skills to sell the leadership of the institution on the role of continuing education. If we are thought of only as a group that provides speakers for traditional physician conferences and charges for the bookkeeping, then pessimism is in order. If we are thought of as experts in education (that is the transmitting of new information in a new and innovative fashion to health care workers), then we are essential for change. The society has laid the groundwork for measuring the impact of education on the changes in health care.

As an academic group with strong collegial ties this group can effect significant change in the coming years. By establishing collaborative research studies and educational opportunities the SMCDCME can measure the course and distance that health care reform has taken.

Appreciation is expressed by the Society to the following companies for their grant support to The Donor Restricted Research in Continuing Medical Education:

Abbott Laboratories
Ciba-Geigy Corporation
Genentech, Inc.
Glaxo Wellcome
Hoechst Marion Roussel
Merck & Company

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Relationships with Associations and Organizations

We were privileged to have representatives from the AAMC, the AMA, and the ACCME attend the Spring Society meeting in St. Louis.

Michael Whitcomb, M.D., Vice President for Education Policy of the AAMC, met with the Board of Directors and attended Thursday morning's session of the Spring program. Dr. Whitcomb represents the AAMC across the continuum for all issues relating to education and internal policy. We were pleased with the opportunity to meet Dr. Whitcomb and look forward to continued interaction.

M. Roy Swartz, M.D., Senior Vice President, Medical Education & Science of the American Medical Association, discussed the environment facing physicians and the standard-setting role of the profession as part of Saturday's session on "Repositioning of Academic CME".

Sue Ann Capizzi, Executive Administrator of the ACCME, met with the Board of Directors to summarize ACCME initiatives and seek recommendations of Society members to serve as ACCME surveyors. The Board was pleased to receive her report and the opportunity for the Society to respond to the ACCME request for input concerning the Essentials, Standards, and the accreditation system as a whole.

Dr. Robert Cullen and Dr. Dale Dauphinee have been appointed Society representatives to the AAMC in their pursuance of providing a "Mini-Medical School" for Congress and staffers that will include an orientation to undergraduate medical education, graduate medical education, and continuing medical education.

Two joint Society plenary sessions are scheduled during the AAMC meeting in Washington - with the Association for Hospital Medical Education (AHME) on "The Team Approach to Health Care - Dynamics and Opportunities" (Sunday, 10:30-11:30 am), and with the Group on Educational Affairs (GEA) of the AAMC on "Are we producing 'good' doctors: How would we know/outcome measures" (Monday, 1:30-2:30 pm). All Society members are encouraged to attend and support these important sessions.

The Accreditation Council for Continuing Medical Education (ACCME) has asked for the identification of SMCDCME members qualified to serve as ACCME site surveyors. This presents a timely opportunity for Society members to assure balanced representation in survey reviews. Interested Society members are encouraged to call my office to receive the application forms (so that a letter of support can follow). The ACCME has offered to provide the mandatory training session just prior to or after the AAMC meeting this fall if there is a sufficient number of applicants from the Society.

Thanks For a Job Well Done

The editors extend warm southern accolades to Spring conference hosts Dr. Mort Smith, and Loretta Giacoletto for a splendid job in St. Louis. The staff were superb and the hospitality couldn't have been better. Thanks y'all!

AAMC Annual Meeting Note:

The SMCDCME Board of Directors will meet Friday, October 27, from 1:00 - 5:00 pm. Standing committees are asked to submit items requiring Board discussion or approval to the president. Committees are encouraged to conduct their work during the interim so our time in Washington can be directed towards issues that the Society can consider and favorably influence. It is hoped this new schedule will afford Board members the opportunity to attend committee meetings, regional meetings, and special interest group meetings, thereby increasing interaction and discussion of issues of concern and interest of the membership.

Access, Resources, and Training for Society Members

All voting members of the Society were sent a "Compendium of Resources on the Effectiveness of CME" - by-product of the Pew/Glaxo Working Group on Academic CME - in May. The group met four times and has forwarded their report to the Pew Charitable Trusts and Glaxo Wellcome educational supporters of the project. The report will become available after their review and comments.

The Research Endowment Council finalized the policies and

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Spring Meeting Report

Lisa Kregel, M.B.A.

If you missed the spring meeting you missed....

- Great networking at committee and regional meetings, special interest groups (SIGs), receptions, a retreat, and everything in between.
- A lively morning, with Roz Lewy moderating, on the integration of CME in managed care. We heard from the perspective of a market analyst, a managed care executive, and an academic CME director.
- Bob Bollinger's wonderful session on research, including the state of CME research, the theory of posing research questions, and opportunities for CME collaboration with health service researchers.
- A fresh look at new techniques. Bill Easterling hosted a session that stretched our thinking from needs assessment to distance learning and telemedicine.
- A crystal-gazing assessment of opportunities and means to reposition academic CME in the medical environment. President George Smith brought together visionary thinkers from the AMA, the VA, and Academic Medical Centers to help us all look into and prepare for the future.

Since I succeeded Nancy Davis as program chair only a short time before this meeting (after Nancy and Loretta Giacoletto's GWU team did 99.9% of the work), I feel no compunction in reporting that it was indeed a magnificent meeting. I have proof too -- with evaluation comments like:

- Excellent meeting
- A+ hospitality and activities
- Beautiful facility!
- Wonderful city, hotel, good planning--Wash U deserves much credit
- Great Program
- The Washington U staff did a superb job of organizing, planning, & implementing details of this meeting & their hospitality was above and beyond the call of duty & well-appreciated
- Program was excellent!

Now don't you wish you had met us in St. Louis? Better plan now to attend the upcoming meetings. In the Fall we meet with the AAMC in Washington, D.C. where we will have sessions Friday - Monday, October 27-30. In Spring 96 we gather in historic Richmond, Virginia, April 10-14. Watch for details in the next *Intercom*.

Shickman And Lockyer Receive Top Society Awards

At the Spring meeting in St. Louis, the Society conferred the "Distinguished Service Award" on Martin D. Shickman M.D. and the "Special Research Award" on Jocelyn M. Lockyer, M.H.A. Both were given for outstanding contributions to the field of continuing medical education. Jack Mason, chair of the Awards Committee, described the contributions of Shickman and Lockyer and President George Smith presented the awards.

Dr. Martin Shickman, better known to his colleagues as "Marty", was cited for his long service to the Society. Since joining the Society in 1976, Dr. Shickman had served on the membership committee, the program committee and for the past five years he chaired the committee on cooperation with industry. He had also been a speaker and/or a workshop leader at most of the recent meetings of the Society. Dr. Shickman served as assistant dean for continuing medical education and as a clinical professor of medicine and cardiology at UCLA from 1973 until his partial retirement in 1993.

Ms. Jocelyn M. Lockyer was cited for her prolific research and publications record in CME. Her accomplishments include being a major collaborator on 13 research projects, presenting 38 invited addresses and workshops, the author or co-author of 51 peer-reviewed journal articles and three book chapters. Ms. Lockyer has been a Society member since 1985 and is currently an adjunct associate professor in the office of medical education at the University of Calgary.

Grand Finale

Incoming president Gloria Allington hosted a reception in St. Louis honoring outgoing president Dr. George Smith and past presidents of the Society.

Roberta Mason and past presidents Dr. Marty Kantrowitz and Dr. Van Harrison.

Treasurer Paul Lambiase, *Intercom* co-editor Carol Malone, and president-elect Dr. Bill Easterling.

Dr. Elmer Brown, left, and Arnie Bigbee, secretary.

A relaxed Dr. George Smith, after handing over the reins to Gloria Allington.

Past Presidents attending are left to right: Drs. George Smith, 1994; Gail Banks, 1979; Van Harrison, 1993; Jim Leist, 1990; Jack Mason, 1991; Bob Cullen, 1989; and Dick Caplan, 1981.

The Buzzwords of the 90s:

Critical Appraisal, Decision Analysis, Variability of Care and Evidence Based Medicine: A "Reader's Digest" Version of the Literature

Urmil Chugh and Jocelyn Lockyer, Office of Continuing Medical Education, The University of Calgary.

There are a number of phrases which have become increasingly popular in the medical literature. This article provides a thumb nail overview of these terms along with the critical citations pertinent to each of these terms. This article is not intended to provide an inclusive overview, but rather to begin the search for appropriate literature as a base for further reading and understanding. In so, it is hoped that it will be helpful to CME providers working with physicians, scientists and policy makers.

Critical Appraisal

DEFINITION: Critical appraisal is a family of activities which maps out steps to assess the scientific rigour (e.g. sample size, validity, etc.) of original research findings as well as reviewing articles on particular subjects. Critical appraisal is, in many ways, synonymous to critically reading the medical literature keeping in mind research techniques and methodology.

GENERAL INFORMATION: Most of the literature dealing with critical appraisal openly admits that they are not attempting a course in research methods, rather, they are providing simplified steps and strategies to conduct critical appraisal (or assess scientific rigour) effectively and efficiently. Most of the articles dealing with the subject, then, map out ways to approach the medical literature[1-5]. Oxman et al[1] outline steps to select useful and relevant studies (both primary studies as well as integrative studies). Three basic questions need to be asked for critical appraisal: are the results of the study valid, what are the results, and will the results help me in caring for my patients?

The above three questions are asked to critically appraise the three areas of following key areas of health care: a) therapy and prevention, b) diagnosis, c) harm, and d) prognosis. Further, several sub-questions can be asked regarding each one of these. For instance, regarding therapy two critical questions can be asked: was the assignment of patients to treatment randomized, and were all the patients who entered the trial properly accounted for and attributed to the conclusions?

Even though it is implicit from the foregoing, it bears repeating that the following criteria should also be met in the process of critically reviewing the primary study: a) the validity of the study, b) the reproducibility of the study, and c) freedom from bias.

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Decision Analysis

DEFINITION: "Decision analysis is a [quantitative and qualitative] method for breaking complex problems down into manageable component parts, analyzing these parts in detail, and combining them in a logical way to indicate the best course of action"[1]

GENERAL INFORMATION: Many of the decisions that health care providers make everyday in their practices are routine and considered "tried and true" practices. Decision analysis has helped physicians, for several years, to make the best possible clinical decisions regarding tough problems.

Decisions analysis is guided by four basic steps: (1) identify the decision problem; (2) structure the decision problem over

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time; (3) measure the uncertainties (probabilities of success and failures) and the utilities of the intervention; and (4) combine the probabilities of successes and failures to choose a preferred course of action.

In the first step, the health care provider implicitly asks precise question about the decision confronting him/her. For instance: is radical hysterectomy the best or preferred course of action for a woman with occult cervical cancer? In the second step, the benefits and the risks of managing the medical problem can be structured in the form of a decision tree. Typically, a decision tree consists of nodes which describe choices (to perform surgery or not) and outcomes (death, infertility etc.). In the above case, two questions can be posed: if radical hysterectomies were to be performed, what are the expected outcomes? If surgery is not performed, what are the expected outcomes? In the third step the caregiver fills in the probabilities of the various outcomes. During this step, the health care provider needs to consult and evaluate the relevant and valid literature and expert advice to determine the probabilities of events. In the absence of objective data from the literature or from local experience, the probabilities still must be computed to preserve the logic of the decision making process. In the above case, without surgery the probability of death from cancer is 0.02 (2%) and survival with fertility is 0.98 (98%). On the other hand, the risk of death after the surgery is calculated to be 0.015. If mortality is the only consideration, then a health provider would choose the surgery route. However, the patient may assess the utilities of fertility (or infertility), and mortality differently and in subjective and non-quantifiable terms. This crucial assessment, in the decision analysis, is done by engaging in constructive dialogue between the health care provider and the patient. The last step of the decision-making process is to assess the uncertainty of the possible outcomes. This is done by means of sensitivity analysis in which each of the key probabilities and values is varied to determine the range of uncertainties resulting from the decision analysis.

Despite the favorable aspects, decision analysis has various weaknesses as the models do not fully represent clinical realities[2] and the difficulty in assigning utilities to the possible outcomes[3]

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Evidence-Based Medicine

DEFINITION: "Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience and pathophysiological rationale as sufficient grounds for clinical decision making and stresses the examination of evidence from clinical research."[1]

GENERAL INFORMATION: Constraints such as limited time and finite resources continue to influence physicians to practice in ways inconsistent with the available research evidence. In the past, organized efforts to reduce the gap between evidence and the clinical practice have been addressed under various rubrics: e.g. total quality management, quality assurance, technology assessment, outcomes management, practice guidelines, audit and continuing medical education[1]. The Evidence-based Care Resource Group[1-5] developed a five part series of articles which develops the framework for evidence-based care and also elucidates the different components or steps of the framework. The four components or steps in order are: (1) setting priorities; (2) setting guidelines; (3) measuring performance; and (4) improving performance.

Regarding the first step, priorities can be either condition-based or system-based. In order to set condition-based priorities the following generic question is posed: How important is the health problem? These priorities are based primarily on risk-benefit (both quantifiable and non-quantifiable) assessment or analysis. Thus, a common condition (e.g. hypertension) is assessed as a high priority. A system-based approach, on the other hand, deals with questions such as: how is the practice organized, and are computerized reminders used?[1]

The second step is to determine an approach or strategy to manage the problem. The following steps facilitate this step: "The first is to formulate questions [e.g. how should one manage a case of acute myocardial infarction in a 45-years-old man?] that are answerable; the second is to locate and synthesize the evidence needed to answer the questions; the third is to estimate the expected benefits, harms and costs of each option based on the evidence; and the fourth is to judge the relative value of the expected out-comes to conclude whether the benefits are worth the harms and costs"[2]

The third step deals with measuring (or auditing) the health care provider's performance in managing the health problem in question. Six generic questions are posed: What is to be measured and the criteria for measurement? Is the needed

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information available? What is the appropriate sampling frame? What should be the size of the sample? How can the information be collected? How will the information be interpreted? In this step, assessing the reliability and validity of the instrument (including medical records) employed to collect the information is also deemed crucial[3].

The fourth step deals with improving clinical performance. Simply put, this step tests the health providers ability to change his/her behaviour. Green, Eriksen & Schor[6] reports that clinical behaviors or actions can be predisposed (by providing available information), or enabled (by assisting with the desired behaviour) or reinforced (by repeating predisposing strategies). The above three strategies of behavioral change can easily be translated into education module for health providers. The education can be directed and/or self- directed. In order to sustain the lessons learned by evidence-based medicine, the health care provider should be prepared to be a life-long self-directed learner of evidence-based medicine[5].

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SMCDCME Internet Listserv

Requires:

Microcomputer with modem or computer terminal
Access to the Internet or Bitnet
...through university
...through commercial source such as CompuServe or MCI Mail

To join:

Send an E-Mail message to:
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In the text of the message:
SUBSCRIBE SMCDCME Your Name

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Variability in Care

DEFINITION: Variability in health care is a concept as well a research area which deals specifically with the reduction in the inappropriate use of medical procedures (e.g. surgery, laboratory tests etc.) without compromising patient health status. It simultaneously addresses the problems of overuse and underuse of medical services. "Quality problems come in three varieties: overuse, underuse and misuse. Overuse is the provision of health services when their benefits exceed their risks; underuse is the failure to provide health services when their benefits exceed their risks; and misuse occurs when an appropriate health services has been selected but is then poorly provided, so that its full potential benefit is not conveyed to the patient."[1]

GENERAL INFORMATION: Geographically based variations in medical procedures have been documented repeatedly[2-4]. Investigators comparing population-based health care utilization rates among geographic areas have demonstrated substantial variations in use among seemingly similar communities. One method of investigating such variations in medical and surgical procedures is small area analysis. "Small area analysis research attempts to use rates among areas, document the amount of variation found in health care use rates among areas, determine whether or not there is 'pattern' to such use in high- versus low-use which is associated with and explains a portion of the variation"[3]. As such, small area analysis measures rates within definite geographic areas. The geographic areas studied can be any size; e.g. communities, a state, a province, or even a country. Considering the variation in medical or surgical procedures as a dependent variable, investigators attempt to correlate it with various independent variables such as, population characteristics, differences in access and need and differences in the health care system (e.g. number of physicians per capita, number of hospital beds etc.) Wennberg & Gittelsohn[2] found that in 193 small areas in New England there were considerable variations in use in the three most common surgical procedures: hysterectomy, prostatectomy and tonsillectomy. The highest rate was six times the lowest one. In the absence of general agreement on the value of these procedures, the style and practice of the individual physician appeared to be the most important determinant of the use.

Thus, one important question is asked in different forms while conducting variation research: Which rate is right? Which rate is appropriate (or inappropriate)? All other things being equal, which rate represents underuse, overuse and/or misuse?

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procedures for review and funding of research projects during the Spring meeting. On behalf of the Society I would like to extend our heartfelt thanks and appreciation to the donors ™ Hoechst Marion Roussel; Glaxo Wellcome; Abbott Laboratories; Genentech; Ciba Geigy; and most recently, Merck & Co. - for their contributions to the Research Endowment Fund of the Society. RFP's are forthcoming.

Society Organizational Structure

Martin D. Hotvedt, Ph.D., has agreed to relieve Dr. James Leist as chair of the development committee. William D. Nelligan continues as SMCDCME charter advisor and development committee member. David F. Lichtenauer and Dr. George Smith have also agreed to serve on the development committee.

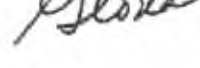
Jean Taylor Bryan and Carol Malone have accepted the positions of co-editors of *Intercom*.

Program and education committees have merged, with Lisa M. Kregel as chair, Rynda W. Gybbs as co-chair.

Dennis R. Lott, chair, strategic planning committee, has agreed to initiate the process required to review our current plan and develop a new, on-going, dynamic plan for the Society.

The bylaws committee and position statements committee have been disbanded; individuals will be appointed, as necessary, to fulfill these functions.

I look forward to this year of office and invite your comments, suggestions, input, and active participation.



Annual Retreat

Dennis R. Lott, D.Ed.

Accreditation issues, information dissemination, CME office abstracts and resources, what's new in CME programming, physician retraining--hot issues and good discussion for the annual retreat. For the 35 Society members who were able to stay for the Sunday retreat at the Spring meeting, it was a chance to continue the long standing Society tradition of an open forum for the discussion of any and all CME issues, concerns, and ideas.

Accreditation Issues

The forum opened with a discussion of accreditation issues. The group was reminded that the Society had been asked to give input to the ACCME regarding suggestions for change in the accreditation process and regulations. A task force under Arnie Bigbee was formed to examine issues and prepare a response for the Society. The task force has already forwarded its recommendation to the Board for action. Everyone was reminded that the ACCME also requested individual feedback.

There seemed to be general agreement that the Essentials were okay, but that paperwork was excessive. Some members commented that process seems to drive everything sometimes to the detriment of outcomes, and that it appears that no attention is being given to encouraging new modes of offering CME. Concerns were raised about the internal ACCME review, with many members expressing a desire for an external, neutral audit of the accreditation process.

Some discussion centered on whether or not CME should be accredited through the LCME at the time of the medical school's accreditation. Additionally, questions were raised concerning the fairness of ACCME accrediting medical schools under the same regulations used to accredit commercial groups or for-profit organizations. For these issues, there were no resolutions, just more questions.

Information Dissemination

The second area of discussion focused on member awareness of Society activities and information dissemination. There was general concern that members were not fully aware of all Society actions, task forces, etc. The Society has a number of initiatives and committees, and information from these groups should be brought before the membership at large on a regular basis.

Several ideas were presented as methods of resolving the communications issues. Some of these ideas included mandates to issue updates from each committee and task force through the *Intercom*. Periodic letters or faxes to the membership with task force and committee information was also suggested. Finally, more effective use of e-mail and the Internet was recommended. For the Society, the most cost effective way to disseminate information may be through the e-mail bulletin boards such as the one operated by Bob Bollinger.

Deb Holmes will be following up on e-mail/Internet connections by conducting a survey of Society membership to determine who is connected, who is not, what we need to do to get members connected, what type of training is needed, and who within the Society can provide leadership for training in these areas. An ideal situation would be to have every Society member connected through the e-mail system thus making information dissemination an easy, effective, efficient process.

CME Office Abstracts and Resources

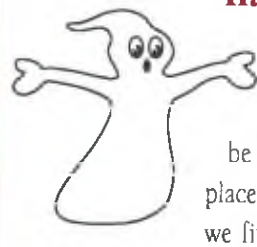
Deb also brought up the third area of discussion as she called for a Society effort to catalog a sketch/abstract of all academic CME offices to include the categories of programs they offer, the types of initiatives (technology, etc.) with which they are involved, and other resources they might bring to the group as a whole. Gloria Allington and Bill Easterling have indicated that they consider this one of their priorities during the next year.

Current Initiatives in CME

Finally, the session ended (although it could have gone on for another hour or so) with discussions about current initiatives in CME. The group discussed PBL Design in CME (not many efforts to date), video taped CME programs (not a very good experience from members present), CD-ROM (judging from sales, many physicians do not have CD-ROM), and the use of the electronic patient record perhaps as a teaching tool (no real data yet on use, effectiveness, examples, etc.). The group also discussed physician retraining and concluded that while retraining may be an issue in the future, it still has not hit many areas or medical schools (at least from the group represented at the retreat).

There was general concern that CME educators will probably be the ones to introduce, use, and ultimately train physicians in the use of new technologies. The concern stems from the issue of allowing technology to dictate use and content rather than using program need and design to dictate the appropriate delivery situation.

Haunting Questions



Overall, the group expressed positive feedback about the continuation of the retreat with some people asking that more time be devoted to the retreat or that perhaps it take place at the beginning of the meeting. In any event, we finished with two haunting questions. What is CME anymore? What makes academic CME better than or distinctive from other CME programs?

For those of you who could not join us this last retreat, why don't you plan to be with us next year. Then you can help us answer these important questions.

Mark Your Calendar

Alliance for CME
21st Annual Conference

Hilton at Walt Disney World
Orlando, Florida
January 17-21, 1996

Society Spring Meeting

Richmond, Virginia April 10-14, 1996

Submissions for *INTERCOM* are welcomed by the Editors. All copy must be typed or printed (double space) preferably in Microsoft Word for Windows 6.0. Send hard copy text and floppy disk by regular mail in a padded envelope to Carol Malone (see page 2 for address). Deadlines and editions are as follows:

Editions	Deadlines
January	December 1
April	March 1
July	June 1
October	September 1

ACCME Update

Murray L. Kopelow, M.D. has been appointed as the first full-time executive director/secretary of the ACCME. Dr. Kopelow is a graduate of the University of Manitoba, Fellow of the Royal College of Physicians and Surgeons of Canada and a specialist in pediatrics. He has also been associate dean for continuing medical education, and faculty of medicine, the University of Manitoba.

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