SOCIETY FOR ACADEMIC
CONTINUING MEDICAL EDUCATION

Survey for 2000

Descriptive Results

Collected February 2000
and including program data for 1998-99

Prepared by the Survey Subcommittee
of the Research Committee

R. Van Harrison, Ph.D., Chair
Nancy Bennett, Ph.D.
Deborah W. Holmes, Ph.D.
John R. Kues, Ph.D.
Paul E. Mazmanian, Ph.D.
John T. Parboosingh, M.D.
John A. Toews, M.D.

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Table of Contents

Introduction

Members of the Research Committee of the Society survey the membership to collect and disseminate information about policies and practices relating to continuing medical education as carried out by colleges and schools of medicine in the United States and Canada. This current survey and its report are intended to fulfill several functions. It provides an overview for all members concerning programming and attendance. It provides newer members with an overview of areas and activities that might otherwise take several years to acquire through informal discussions. It provides longer term members an update on general information and a clearer understanding of specific activities. For all members it provides the occasion to compare their CME units with those of other member schools, to recognize the extent to which they are similar to or different from the other schools, and to identify issues that the similarities and differences suggest for ways to improve the functioning of their units.

The survey focuses on continuing medical education for physicians. Many units providing CME also provide continuing education for other health professions. Recognizing the purpose of the Society, the survey does not include information on activities aimed primarily at groups other than physicians. This focus provides information that is more comparable across medical schools.

All attempts to represent reality have their limitations. The survey is an excellent way to present aggregate data on a number of dimensions. However, it cannot represent the complex factors operating simultaneously at any one school. The report should be used to obtain a general perspective. Finer distinctions about any one school are not appropriate without additional inquiry.

The limited size of the population--141 medical schools (125 in the United States and 16 in Canada), 112 of which are currently members of the Society--and the typical response rate (60 to 85 schools) provides sample sizes with the statistical power to detect only substantial differences on measures that are significant at the .05 level (5 chances in 100 that the observed difference is not random). However, differences of moderate and small size may be important for administrative and policy decisions. Therefore, this descriptive report presents data and discusses them briefly in the context of factors known to be operating in the CME environment. Issues of particular interest are typically

addressed individually in subsequent articles published in professional journals. These articles are more detailed in both the statistical analysis of data and discussion of results.

TABLE 1. Percent of Institutions Returning the Survey by Geographic Region

	North-East	Mid-West	South	West	Canada	Total
Number of Institutions	30	26	34	14	8	112
Number Returning Questionnaires	14	16	21	7	4	62
Response Rate	47%	62%	62%	50%	50%	55%

TABLE 2. Response Rates for Biennial SMCDCME Surveys

Year	Number Sent	Number Returned	Response Rate
1986	120	63	53%
1988	120	58	48%
1990	118	72	61%
1992	117	65	56%
1994	114	75	66%
1996	121	89	74%
1998	122	82	67%
2000	112	62	55%

The methods used to collect the data and some comments concerning the representativeness of data are presented below. The first three sections of descriptive results are routinely included in recent surveys: programs and attendees, course fees, and current trends. The next two sections have been included in previous surveys and updated results are presented in this survey: research in CME units and financial involvement of commercial companies. The eight following sections are on topics unique to this survey. The report text concludes with a summary of the patterns seen across the various areas included in the survey. The responding institutions are acknowledged at the end.

Methods

The questionnaire was developed by members of the Survey Subcommittee of the Research Committee of the Society. Its content was derived from the content of previous surveys of the Society, suggestions of society members to the Research Committee, and suggestions developed by the Subcommittee as they met and revised the survey content. Items in the survey are introduced in the results section along with the results for the item.

The survey was sent out in January, 2000 to the voting members of the 112 medical schools and colleges in the United States and Canada having membership in the Society. A reminder to return the survey was sent to institutions that had not responded by the last week of February, 2000. The responses were returned from February through mid-March, 2000.

Table 1 presents the response rates in returning the questionnaire. Sixty-two of the medical schools (55%) returned the survey. As indicated in Table 1, response rates by geographic region ranged from 47% in the northeastern U.S. to 62% in the mid-west and the south.

Table 2 summarizes the previous response rates for the biennial survey. The response rate for this survey is lower than for the previous three surveys. While the reason for the lower response rate is not certain, anecdotal evidence suggests that most medical school CME units are unusually busy this year with less time for optional activities. The increases in number of activities, described below, support this explanation.

Although the medical schools responding to past surveys and the present survey are not identical, a general assumption is made that they are sufficiently similar that comparisons are made between current data and parallel data reported previously. However, trends across time must be interpreted cautiously because some change across years will be due to

differences in the specific institutions returning the surveys across the years.

TABLE 3 Distribution of Medical Schools on Annual Number of Courses, CME Hours, External Physician Participants, and Other External Participants

Courses & Conferences for External Physicians	Medical Schools	Course CME Hours	Medical Schools	External Physician Participants	Medical Schools	Other External Participants	Medical Schools
0-19	6	0-199	6	0-999	10	0-999	17
20-39	12	200-399	7	1,000-1,999	9	1,000-1,999	12
40-59	10	400-599	6	2,000-2,999	8	2,000-2,999	11
60-79	7	600-799	12	3,000-3,999	11	3,000-3,999	5
80-99	9	800-999	5	4,000-4,999	1	4,000-4,999	5
100-119	6	1,000-1,199	6	5,000-5,999	7	5,000-5,999	3
120-139	6	1,200-1,399	3	6,000-7,999	3	6,000-7,999	2
140-over	6	1,400-1,599	1	8,000-9,999	2	8,000-9,999	0
		1,600-1,799	5	10,000-11,999	3	10,000-11,999	2
		1,800-1,900	3	12,000-over	5		
		2,000-over	6				
Total Schools	61	Total Schools	60	Total Schools	59	Total Schools	57

Note: Data are for the year from July 1998, through June 1999, or the closest 12 month reporting period.

The return of the survey did not necessarily mean that data were available for every item. Some items did not apply to all institutions and some items were not completed by some institutions. A major factor in providing data was the extent to which the CME unit already kept data in a format similar to that requested by the survey, for example, data for physician oriented programs were already separate from data for other programs, attendance data were kept separately for external participants and internal participants. When an item did not apply to an institution it was sometimes left blank and the distinction between missing data and "does not apply" or "zero" was not always clear. The number of responses on which the data are based varies from item to item and therefore the total number of responding schools is usually presented for each item. Also, median values (50th percentile) are reported when extreme values for a few institutions would disproportionately affect mean values.

Two time frames are used in presenting data. Some items concern aspects of CME activities over a 12 month period. Information for these items was requested for the last academic year (typically 1998-99) or other recent annual reporting period used by the institution. Other items asked about operations and opinions at the time the survey was being completed – about February, 2000. The applicable time period is shown when data are presented for more than one year.

Descriptive Results

Programs and Attendees

Difficulties sometimes arise because people use the same terms to mean different things. Respondents must use terms with common definitions for responses to be comparable. Therefore, this section of the questionnaire began with a page of definitions concerning courses and attendees. The text is reproduced as the Appendix. The defined terms were then used to specify a primary interest in responses concerning live multiple hour and multiple day courses, conferences and seminars oriented to external physicians.

Courses, credit hours, and attendees. Table 3 presents the distributions of medical schools on the annual number of courses oriented to external physicians, on the category 1 credit hours designated for these courses, and on the total attendance at these courses by physicians and others external to the institution. The 25th, 50th and 75th percentiles for these variables are shown in Table 4 for seven previous surveys as well as for the current one.

Medical schools vary widely on the annual number of courses oriented to external physicians (Table 3). Table 4 shows a doubling in number of courses from 1984-85 to 1990-91. From then to 1994-95 the number of courses appears to have decreased slightly. In 1996-97 the number of courses returned to the 1990-91 levels. In 1998-99 the number of courses increased to the highest levels seen.

As shown in Table 3, the distribution on total course CME hours is fairly wide. The 25th, 50th, and 75th percentiles are shown in Table 4. The number of course hours increased until 1992-93, remained fairly stable through 1996-97, then increased in 1998-99.

The third section of Table 3 shows that the attendance by external physician participants is less widely dispersed. Table 4 presents the 25th, 50th, and 75th percentiles for recent surveys. The number of external physician participants

increased until 1992-93, was generally stable in 1994-95, and increased in 1996-97 and again in 1998-99.

TABLE 4 Distribution (Quartiles) of Medical Schools on
Annual Number of Courses Oriented to External Physicians,
CME Hours, External Physician Participants, and Other External Participants

	Reporting Year	25th Percentile	50th Percentile	75th Percentile	Total Schools
Number of Courses for	1984-85	16	32	52	47
External Participants:	1986-87	22	34	56	56
	1988-89	29	46	60	61
	1990-91	30	61	100	61
	1992-93	32	57	94	71
	1994-95	31	50	78	84
	1996-97	32	61	96	81
	1998-99	34	67	104	61
Number of CME	1988-89	257	415	653	59
Hours Certified:	1990-91	284	468	944	60
	1992-93	314	554	1,114	72
	1994-95	243	507	1,000	82
	1996-97	302	617	1,087	81
	1998-99	477	754	1,540	60
Number of External	1988-89	1,000	2,078	3,300	59
Physician Participants	1990-91	1,200	2,039	3,957	61
	1992-93	1,240	2,552	5,000	73
	1994-95	1,273	2,537	4,538	82
	1996-97	1,519	2,815	4,959	81
	1998-99	1,418	3,314	5,481	59
Number of Other	1988-89	350	500	1,000	52
External Participants	1990-91	293	850	1,731	56
	1992-93	400	1,414	2,281	67
	1994-95	517	1,208	2,522	80
	1996-97	445	1,237	2,358	77
	1998-99	792	1,983	3,377	57

The number of other external participants is not always recorded in a way that is convenient to report, resulting in the lower response rate for this item. For the courses oriented to external physicians, the last section of Table 3 shows that the number of other external attendees clusters fairly tightly at less than 3,000 for the majority of schools. Table 4 presents the 25th, 50th, and 75th percentiles. Again increases occurred through 1992-93, then another increase occurred in 1998-99.

Other CME activities. Medical schools can engage in a number of additional CME activities. Data on the other formats for "live" CME are presented in Tables 5. Data on enduring self-study CME activities are presented in Table 6. The column ranges reflect natural clustering of medical schools; the ranges are usually not equal across columns.

The first section of Table 5 displays the number of presentations at county medical societies and local hospitals that were arranged by the CME unit. Presentations of this type are arranged by just over half of the medical schools, although the number of presentations varies substantially. The results across recent years suggest that fewer medical schools are arranging these presentations across the years.

Some CME units conduct conferences by telephone. Table 5 presents the number of medical schools presenting single session telephone conferences and multiple session telephone conferences. The substantial majority of CME units are not involved with either single or multiple session telephone

conferences. The results appear to be fairly stable across years.

TABLE 5. Distribution of Medical Schools on Annual Number of Some Other Types of "Live" Externally Oriented CME Activities

	Reporting Year	0	1-50	51-100	101-200	201-400	>400	Total Schools
Number of School Sponsored Presentations at Local Medical Societies and Hospitals:	1984-85	31%	37%	11%	15%	4%	2%	54
	1986-87	18%	35%	11%	24%	5%	7%	55
	1988-89	25%	33%	22%	8%	6%	6%	72
	1990-91	23%	49%	5%	12%	9%	2%	57
	1992-93	32%	42%	17%	5%	3%	1%	72
	1994-95	38%	39%	4%	13%	4%	2%	53
	1996-97	40%	41%	9%	7%	2%	1%	80
	1998-99	46%	30%	10%	12%	0%	2%	57

	Year	0	1-10	11-50	>50	Schools
Number of Single Session Telephone Conferences:	1988-89	83%	10%	6%	1%	72
	1990-91	83%	12%	3%	2%	58
	1992-93	86%	11%	3%	0%	71
	1994-95	88%	6%	6%	0%	53
	1996-97	86%	4%	6%	4%	80
	1998-99	86%	6%	4%	4%	56
Number of Multiple Session Telephone Conferences:	1988-89	94%	5%	1%	0%	72
	1990-91	88%	9%	3%	0%	57
	1992-93	92%	4%	3%	1%	71
	1994-95	89%	9%	2%	0%	86
	1996-97	81%	13%	3%	3%	80
	1998-99	86%	12%	2%	0%	57
Number of Single Session Video Conferences:	1988-89	71%	22%	1%	6%	72
	1990-91	79%	16%	5%	0%	58
	1992-93	76%	20%	4%	0%	71
	1994-95	70%	29%	1%	0%	87
	1996-97	70%	23%	6%	1%	80
	1998-99	79%	12%	9%	0%	58
Number of Multiple Session Video Conferences:	1988-89	92%	8%	0%	0%	72
	1990-91	86%	10%	3%	0%	58
	1992-93	93%	4%	3%	0%	71
	1994-95	83%	16%	1%	0%	81
	1996-97	75%	21%	3%	1%	80
	1998-99	75%	21%	4%	0%	57
Number of Single Session Internet Broadcast Conferences	1996-97	95%	5%	0%	0%	80
	1998-99	93%	7%	0%	0%	57
Number of Multiple Session Internet Broadcast Conferences	1996-97	95%	5%	0%	0%	80
	1998-99	98%	2%	0%	0%	57

(Table 5 Continues on next page)

TABLE 5 (continued). Distribution of Medical Schools on Annual Number of Some Other Types of "Live" Externally Oriented CME Activities

		0	1-20	21-60	61-300	Schools
Number of Individuals	1984-85	39%	45%	8%	8%	53
in Tutorials or Traineeships:	1986-87	42%	33%	16%	9%	57
	1988-89	46%	33%	16%	9%	72
	1990-91	48%	36%	8%	4%	61
	1992-93	49%	37%	8%	6%	72
	1994-95	54%	28%	9%	9%	80
	1996-97	52%	33%	5%	10%	80
	1998-99	54%	32%	12%	2%	57

The survey also asked about single and multiple session closed circuit televised conferences. Table 5 shows that the substantial majority of medical schools are not involved with television conferences, although about a quarter of the schools are involved with some single session televised conferences. The results appear to be fairly stable across years.

This year the survey asked how many of the televised conferences were transmitted by satellite and how many were two-way interactive. A total of 172 single session televised conferences were reported. Of these 90 (53%) were broadcast by satellite and 162 (94%) involved two-way interactive communication. A total of 79 multiple session (series) televised conferences were reported. Of these 21 (27%) were broadcast by satellite and 52 (66%) involved two-way interactive communication. It appears single session conferences are more likely to be broadcast by satellite and multiple session conferences are more likely to be broadcast by closed circuit. It also appears that single session video conferences are almost always interactive and that multiple session video conferences are typically interactive.

For the second time this survey asked about conferences broadcast over the Internet. Very few schools are broadcasting either single session conferences or multiple session conferences by Internet. Of the 5 single session conferences, 2 involved two-way interactive communication. The one reported multiple session conference involved two-way interactive communication.

The last section of Table 5 addresses individual tutorials and traineeships. About half of the medical schools offer tutorials or traineeships, but usually to a low number of individuals. Results across years suggest a slight reduction in the number of schools and individuals involved in this type of CME.

Still another form of CME is the self-study course using some type of enduring material. For several years Society surveys have asked about the total number of individuals participating in self-study for credit. In 1992-93 the survey expanded the questions in this area. It also asked for the number of self-study activities developed/produced, asked for the data separately by type of medium (written, audio, video), and added computer based self-study. The 1994-95 survey further differentiated between computer self-study offered on disk or CD ROM and computer self-study offered by direct connection through the Internet.

Table 6 presents the distribution of medical schools on the number of self-study courses produced and the number of individuals given credit. In 1998-99, approximately two-thirds of the medical schools produced written self-study, an increase over past years. A quarter produced audio self-study, about the same as in recent years. Less than half produced video self-study, about the same as in recent years. A third produced computer self-study based on disk, an increase over previous years. Almost half produced computer self-study based on the Internet, a substantial increase over previous years. However, schools producing these types of enduring materials typically produced only a few (1 - 10) of them and relatively few (1 - 200) participants used them for credit.

When all types of self-study activities were added together for each school (bottom of Table 6), 82% of medical schools produced some type of enduring self-study material. Across years, there is a trend for an increasing number of schools to produce enduring materials, with the biggest recent increase in print and computer based materials. Across the years there is also a trend for an increase in the number of individuals using self-study materials to receive credit, particularly an increase in the number of schools reporting more than 1,000 participants using enduring materials.

Across all the types of self-study activities the increase is greatest over the past two years. Written self-study activities are the format with the largest increases.

The survey asked about CME activities oriented primarily to "internal" physicians, i.e. physicians who are faculty of the medical school. The questions and results are summarized in Table 7.

Virtually all schools designate credit for some ongoing multiple session internal activities like grand rounds. However, schools vary widely on the number of these activities. The 25th, 50th, and 75th percentiles are 12, 30, and 68. The respective percentiles in 1996-97 were 17, 35, and 80. Apparently the number of these types of activities for credit decreased somewhat over the two year period.

TABLE 6. Distribution of Medical Schools on Annual of Written, Audio, Video, and Computer Self Study Courses and Number of Individuals Receiving Credit for Them

		No. of Activities Produced				No. of Individuals Receiving Credit						
		0	1-10	11-50	50-100	0	1-200	201-500	501-1000	1001-10000	>10000	Total Schools
Written Self-Study (including journals)	1992-93	56%	41%	3%	0%	68%	20%	8%	3%	1%	*	71
	1994-95	51%	43%	6%	0%	52%	26%	5%	6%	11%	*	82
	1996-97	46%	46%	8%	0%	51%	26%	8%	4%	11%	*	80
	1998-99	32%	57%	9%	2%	35%	23%	7%	8%	23%	4%	52
Audio Self-Study	1992-93	93%	6%	1%	0%	95%	4%	1%	0%	0%	*	71
	1994-95	78%	22%	0%	0%	82%	13%	1%	1%	3%	*	81
	1996-97	79%	21%	0%	0%	82%	16%	1%	0%	1%	*	80
	1998-99	77%	21%	2%	0%	83%	11%	0%	2%	4%	0%	47
Video Self-Study	1992-93	82%	13%	4%	1%	86%	9%	4%	1%	0%	*	71
	1994-95	56%	43%	1%	0%	65%	21%	5%	5%	4%	*	81
	1996-97	56%	43%	1%	0%	60%	32%	0%	4%	4%	*	80
	1998-99	60%	38%	2%	28	62%	26%	0%	2%	6%	4%	50
Self-Study Computer SS: Disk	1994-95	85%	15%	0%	0%	91%	5%	3%	0%	1%	*	80
	1996-97	78%	21%	1%	0%	80%	18%	0%	0%	1%	*	80
	1998-99	69%	29%	2%	0%	71%	17%	0%	0%	0%	2%	48
Computer SS: Internet	1994-95	91%	9%	0%	0%	97%	3%	0%	0%	0%	*	79
	1996-97	75%	25%	0%	0%	80%	18%	1%	1%	0%	*	80
	1998-99	53%	45%	2%	0%	60%	32%	2%	4%	2%	0%	47
All Types of Self-Study Combined	1984-85	(not collected)				67%	17%	7%	5%	4%	*	54
	1986-87	(not collected)				51%	19%	21%	0%	9%	*	58
	1988-89	(not collected)				48%	32%	7%	6%	7%	*	72
	1990-91	(not collected)				55%	24%	3%	8%	10%	*	62
	1992-93	52%	37%	10%	1%	66%	16%	7%	10%	1%	*	71
	1994-95	39%	51%	10%	0%	45%	25%	8%	5%	17%	*	77
	1996-97	28%	51%	23%	0%	30%	39%	10%	5%	16%	*	80
	1998-99	18%	57%	21%	4%	22%	30%	4%	11%	29%	4%	54

Note: Until 1992-93 information was collected only for the total number of individuals receiving credit for all types of self-study.

* Until 1998-99 the highest category for number of individuals receiving credit was >1000, combining 1000 to 10000 and >10000.

Regarding single occasion internal activities for credit, approximately one-third of the schools indicated "none". For many of these schools the answer may be somewhat misleading. External physicians are also invited and a number of schools include this type of activity in the counts of externally oriented courses included in Tables 3 and 4. Among the half of schools reporting on single occasion internal CME activities, the majority had under 10 activities. The 25th, 50th, and 75th percentiles are 0, 2, and 12, reflecting a slight increase over the 1996-97 respective percentiles of 0, 0, and 8.

To assess the extent to which there are internal CME activities that are not receiving credit, the survey asked: "How many CME activities were held for which credit was <u>not</u> designated, but could probably have had credit if the 'paper work' requirements (documentation of planning, attendance, evaluation) had been performed?". The responses are in the last section of Table 7. For the majority (63%) of schools the answer is none or few (< 10). For 10% of schools the answer is a substantial (> 25) number. The distribution reflects a slight increase over 1996-97 in the number of activities that could have credit with "paperwork". (This increase may be due to the decrease in the number of multiple session activities actually receiving credit, noted in the first part of Table 7.)

TABLE 7. Distribution of Medical Schools on Annual Number of CME Activities Oriented Primarily to Internal Physicians

		0	1-10	11-25	26-75	76-150	>150	Total Schools
Series/multiple activities (e.g., grand founds) for credit	1996-97	1%	11%	25%	35%	20%	8%	76
	1998-99	5%	18%	24%	33%	12%	8%	60
Single occasion activities for credit	1996-97	52%	29%	8%	8%	1%	2%	77
	1998-99	33%	41%	12%	10%	2%	2%	49
Activities without credit, but with "paperwork" could have credit	1996-97	24%	36%	22%	13%	5%	0%	76
	1998-99	14%	49%	17%	13%	7%	0%	56

TABLE 8. Distribution of Medical Schools on Usual Fee Per Credit Hour

Usual Fee per Credit Hour	Distribution for Courses At: Primary Location	"Pleasure" Locations
$0	2	3
$1 to $6	0	0
$7 to $9	1	0
$10 to $12	14	2
$13 to $15	13	3
$16 to $18	5	3
$19 to $21	9	5
$22 to $24	3	4
$25 to $27	9	12
$28 to $31	2	6
$32 or more	0	6
Total Schools	58	50

Course Fees

The questionnaire asked for the usual fee per credit hour for courses without unusual outside financial support, separating courses at the primary (home location) from courses at "pleasure" locations. The distribution of responses is presented in Table 8. As in past reports, the fee per credit hour varies greatly across schools.

The extent of change in course fees across the past years is indicated in Table 9. The table presents the 25th, 50th, and 75th percentiles for fees per credit hour from the current and past surveys. The top half of the table shows that for courses at the institution's primary location, the fees in 2000 appear to have increased slightly over the relatively stable levels since 1992.

The lower half of Table 9 shows that the fee per credit hour for courses at "pleasure" locations has tended to increase somewhat across the years. The fees for 2000 appear to have increased slightly over those of recent years.

Current Trends

The survey included a section asking for impressions about current trends for several aspects of CME at medical schools. The information represents the perception of directors of CME units concerning trends at the time the questionnaire was completed (February, 2000). The distribution of medical schools on the responses is presented in Table 10 along with the data for the same items when they were asked in previous surveys. The mean response for each item (coded from 1 = “decreasing a lot” to 5 = “increasing a lot” is also presented. With 3.0 reflecting no overall change, means < 3 indicate a decreasing trend and means > 3 indicate an increasing trend.

TABLE 9. Distribution (Quartiles) of Medical Schools on Usual Fee Per Credit Hour Across Biennial Surveys

	Reporting Year	Usual Fee Per Credit Hour 25th Percentile	50th Percentile	75th Percentile	Total Schools
Courses at	1986	$10	$12	$15	51
Primary Location:	1988	$10	$15	$17	54
	1990	$10	$15	$18	70
	1992	$12	$15	$20	62
	1994	$10	$15	$20	72
	1996	$12	$15	$20	79
	1998	$12	$15	$20	75
	2000	$12	$16	$23	58
Courses at	1986	$14	$16	$20	45
"Pleasure" Location:	1988	$15	$20	$22	46
	1990	$16	$20	$25	57
	1992	$18	$21	$25	48
	1994	$15	$23	$28	64
	1996	$18	$23	$28	64
	1998	$18	$25	$30	67
	2000	$20	$25	$32	50

Many means fall between 2.8 and 3.2, indicating only a slight trend, if any.

The number of courses for external physicians is increasing somewhat at half the schools. The overall trend is a slight increase, continuing a long term trend of slight increases.

The responses indicate that the number of external physicians per course is most frequently "increasing a little." The overall trend is between "no change" and "slight increases."

Attendance at courses at "pleasure" locations shows a majority with no change, continuing stability after decreases a few years ago.

Faculty interest for participating in the medical school's CME is widely distributed, with increases noted at more schools than decreases. The tendency for a slight increase has been stable for several years.

Faculty interest for participating in CME produced by other sponsors is largely stable.

Trends in financial support for CME from the university are stable at over half the schools. For schools with changes, the number with decreasing support is similar to the number with increasing support, but the magnitude of decreases tends to be slightly larger than the amount of increases. The trend over years is a sustained slight decrease in support from the university.

Financial support from commercial companies is increasing "a little" at half the medical schools. The net increase changes the pattern of recent years when commercial support tended to decrease.

The quality of courses is viewed as increasing to some extent at over half the schools. The trend across years is for fairly stable reports of increasing quality.

The time between registering and the course date is stable at half the schools and tending to decrease at a substantial minority of schools. The responses are similar to those in past years, showing a modest trend to later registration across time.

The overall summary of current trends is that the largest changes are increases in the number of courses, in the commercial support for courses, and in the quality of courses and for slight decreases in the time between registering and the course date. For the other items, the overall trend is close to no change, but with some individual institutions experiencing changes in both decreasing and increasing directions.

When looking at trends across years, the biggest change is the shift toward increasing commercial support. The trends across time on the other measures have been generally similar for several years. Sustained trends for appreciable increases are in the quality of courses and in the number of courses offered. Sustained trends for slight increases are in faculty interest in participating in both the school's CME and other

sponsor's CME and in the number of external physicians per course. A

TABLE 10. Distribution of Medical Schools on Current Trends in Various Aspects of CME

	Year (Reported in February)	Current Trend Is: Decreasing A Lot [1]	Decreasing A Little [2]	No Change [3]	Increasing A Little [4]	Increasing A Lot [5]	Mean [1-5]	Total Schools
Number of Courses	1990	0%	10%	29%	46%	15%	3.7	70
for External Physicians:	1992	3%	16%	28%	50%	3%	3.3	64
	1994	0%	27%	26%	43%	4%	3.2	70
	1996	2%	23%	36%	35%	4%	3.2	88
	1998	2%	21%	24%	42%	11%	3.4	81
	2000	2%	19%	16%	55%	8%	3.5	62
Number of External	1990	0%	20%	33%	37%	10%	3.4	69
Physicians per Course:	1992	2%	19%	43%	35%	2%	3.2	63
	1994	1%	34%	34%	27%	4%	3.0	71
	1996	1%	33%	38%	27%	1%	2.9	88
	1998	1%	33%	27%	36%	3%	3.1	80
	2000	5%	26%	14%	53%	2%	3.2	62
Attendance at Courses	1990	3%	12%	60%	23%	2%	3.1	65
at "Pleasure" Locations:	1992	5%	15%	64%	15%	1%	2.9	61
	1994	10%	21%	47%	21%	1%	2.8	71
	1996	11%	30%	41%	17%	1%	2.7	83
	1998	3%	14%	54%	29%	0%	3.1	79
	2000	5%	11%	63%	21%	0%	3.0	57
Faculty Interest in	1990	0%	3%	31%	53%	13%	3.8	58
Participating in Your	1992	3%	6%	37%	48%	6%	3.5	63
School's CME	1994	1%	12%	41%	36%	10%	3.4	73
	1996	2%	24%	36%	31%	7%	3.2	89
	1998	5%	21%	33%	32%	9%	3.2	81
	2000	7%	16%	34%	37%	6%	3.2	62
Faculty Interest in	1990	0%	5%	55%	33%	7%	3.4	70
Participating in Other	1992	5%	4%	69%	20%	2%	3.1	55
Sponsors' CME	1994	2%	4%	79%	13%	2%	3.1	62
	1996	1%	11%	69%	18%	1%	3.1	78
	1998	4%	7%	66%	20%	3%	3.1	74
	2000	2%	7%	67%	20%	6%	3.2	62
Financial Support for	1990	6%	21%	54%	16%	3%	2.9	70
CME from University:	1992	9%	25%	52%	12%	2%	2.7	64
	1994	12%	18%	55%	14%	1%	2.7	73
	1996	16%	25%	47%	11%	1%	2.6	89
	1998	11%	10%	59%	18%	1%	2.9	80
	2000	5%	16%	60%	17%	2%	2.9	62

(Table 10 continues on next page)

TABLE 10 (continued). Distribution of Medical Schools on Current Trends in Various Aspects of CME

	Year (Reported in February)	Current Trend Is: Decreasing A Lot [1]	Decreasing A Little [2]	No Change [3]	Increasing A Little [4]	Increasing A Lot [5]	Mean [1-5]	Total Schools
Financial Support for	1990	0%	13%	39%	39%	9%	3.4	69
CME from Commercial	1992	2%	23%	33%	37%	5%	3.2	64
Companies:	1994	16%	39%	23%	19%	3%	2.5	73
	1996	8%	44%	19%	25%	4%	2.7	89
	1998	15%	19%	28%	36%	2%	2.9	81
	2000	2%	22%	20%	51%	5%	3.4	62
Quality of Courses	1990	0%	0%	28%	55%	16%	3.8	67
for External Physicians:	1992	0%	0%	34%	55%	11%	3.8	64
	1994	0%	4%	25%	58%	13%	3.8	72
	1996	0%	1%	33%	56%	10%	3.8	89
	1998	0%	0%	30%	62%	8%	3.8	79
	2000	0%	2%	28%	57%	13%	3.8	62
Time between registering	1996	13%	21%	56%	10%	0%	2.6	89
& course date:	1998	12%	24%	51%	11%	1%	2.7	78
	2000	8%	28%	50%	11%	3%	2.7	60

sustained trend for little change is found for attendance at courses at “pleasure” locations. A sustained trend for slight decreases is found for financial support for CME from the university and for time between registering and the course date.

Research in CME Units

CME units vary in the extent to which research is part of the unit's activity. This section of the survey was developed to clarify the extent to which research concerning CME is being performed by CME units and by others at medical schools and their associated universities. Items about research in CME units were previously included in the surveys for 1990, 1994, and 1998, which are updated in the current survey.

The survey included five interrelated items concerning CME units and research on CME, with the responses presented in Table 11. Of the schools, 31% have research projects based in the CME unit, 24% have CME unit personnel doing research based in other units on CME, 30% have CME unit personnel doing research based in other units on undergraduate/graduate medical education, 37% have non-CME unit personnel doing CME research, and 29% have CME unit personnel doing research in other units on non-CME topics (e.g., physicians performing clinical research). The involvement in research has increased in all of these areas.

Another item asked, "In roles and assignments in your CME unit, what is the approximate full time equivalent of senior personnel spent on research?" The results are presented in Table 12. Most (71%) CME units do not have senior personnel spending time on research. Of the remainder, it is most common for this to be a minor portion (0.1 to 0.3 FTE) of someone’s role. Compared to previous years, the results show an increased amount of senior personnel time spent on research.

The final question concerning research asked about the approximate annual research revenue of the CME unit by revenue source. The distribution of responses is presented in Table 13. A quarter of CME units received research revenue. The principal source of this revenue is external grants, which also provide the largest amounts of funding. Less frequent sources are “other” sources, conference fees, and university funds. The CME units that receive funding from these “less frequent” sources are usually also receiving external grant funds. While CME units with research funding are in the minority, their number has increased over the last two years.

Financial Involvement of Commercial Companies

An ongoing topic of discussion is the extent to which pharmaceutical, instrument, and other companies provide financial support to CME activities. Questions about commercial support for courses, conferences, and seminars oriented to external physicians were first asked in 1988 as part

of the survey for 1986-87 and asked again four years later in the 1992 survey. Just at that time substantial changes regarding commercial support were being announced, most

TABLE 11. Distribution of Medical Schools on Questions Regarding Research and CME

	Year	No	Yes	Total Schools
Research projects based within CME unit?	1990	81%	19%	72
	1994	82%	18%	74
	1998	78%	22%	81
	2000	69%	31%	61
CME unit personnel doing research based in other units on CME?	1990	67%	33%	69
	1994	76%	24%	72
	1998	*	*	*
	2000	59%	41%	56
CME unit personnel doing research based in other units on undergraduate/graduate medical education?	1990	67%	33%	63
	1994	70%	30%	71
	1998	*	*	*
	2000	56%	44%	50
Non-CME unit personnel doing CME research?	1990	69%	31%	68
	1994	63%	37%	70
	1998	*	*	*
	2000	59%	41% **	59
CME unit personnel doing research in other units on non-CME topics?	2000 [new item)	71%	29%	52

*Data not collected appropriately.
** With 24% of 59 schools having this research done in collaboration with CME unit.

TABLE 12. Distribution of Medical Schools on Full-Time Equivalents of Senior Research Personnel in CME Unit

	0	0.1-0.3	0.4-0.6	0.7-1.0	1.1-5.0	Total Schools
1990	81%	11%	7%	1%	0%	72
1994	82%	12%	2%	1%	3%	74
1998	79%	13%	6%	1%	1%	80
2000	71%	16%	5%	3%	5%	60

Note: For schools with research projects based within the CME unit.

notably: in 1991 the American Medical Association issued its Ethical Opinion on Gifts to Physicians from Industry, in 1992 the Accreditation Council for CME expanded its Standards for Commercial Support of Continuing Medical Education, and in 1992 the Food and Drug administration issued its Draft Policy Statement Related to Industry-Supported Scientific and Educational Activities. Since that time a number of policy and operational changes regarding commercial support have been implemented at medical schools.

Commercial support for CME courses. The distribution of medical schools on (a) the annual number and (b) the percent of courses with financial support from commercial companies is presented in Table 14. Regarding the number of courses receiving support, in 1998-99 almost all institutions received commercial support for several courses, with a wide variation in the number of courses that receive support (Table 14, part a.). Comparing the number of courses receiving support across the years, the trend across years is for medical schools to have a higher number of courses receive commercial support. This is more clearly evident in the first section of Table 18, which shows the 25th, 50th, and 75th percentiles on the number of courses receiving support across the 12 years. The median (50^{th} percentile) number of courses went from 26 in 1994-95 to 38 in 1998-99.

The number of courses produced by an institution with commercial support is best interpreted in relation to the total number of courses offered by the institution. For this reason,

TABLE 13. Distribution of Medical Schools on Amount and Source of Research Revenue to CME Unit

Revenue Source	Year	Revenue Amount					Total Schools
		$0	$1 to $5,000	$5,001 to $10,000	$10,001 to $50,000	$50,001 to $300,000	
External grants	1990	89%	4%	0%	6%	1%	72
	1994	92%	0%	1%	4%	3%	73
	1998	88%	0%	0%	6%	6%	81
	2000	76%	5%	0%	10%	9%	58
Other	1990	99%	0%	1%	0%	0%	72
	1994	97%	0%	0%	3%	0%	73
	1998	100%	0%	0%	0%	0%	81
	2000	95%	3%	2%	0%	0%	57
Conference fees	1990	89%	7%	3%	1%	0%	72
	1994	99%	1%	0%	0%	0%	73
	1998	98%	0%	1%	0%	1%	81
	2000	93%	3%	0%	2%	2%	57
University	1990	97%	3%	0%	0%	0%	72
	1994	95%	3%	1%	1%	0%	73
	1998	96%	1%	0%	2%	1%	81
	2000	91%	2%	0%	7%	0%	58
Total of sources	1990	83%	6%	3%	7%	1%	72
	1994	86%	3%	0%	7%	4%	73
	1998	88%	0%	0%	6%	6%	81
	2000	75%	3%	2%	8%	12%	58

Note: This table treats missing data (i.e. blank response) as zero revenue from the source.

TABLE 14. Distribution of Medical Schools on Number and Percent of Courses with Financial Support from Commercial Companies

Reporting Year	a. Number of Courses with Commercial Support							Total Schools
	0	1-10	11-20	21-40	41-60	61-80	81-150	>150	
1986-87	4%	31%	31%	26%	4%	2%	2%	0%	51
1990-91	7%	14%	28%	29%	5%	10%	7%	0%	58
1994-95	0%	15%	22%	37%	16%	5%	5%	0%	86
1998-99	3%	7%	11%	33%	17%	8%	17%	4%	58
	b. Percent of Courses with Commercial Support								
		0%	1%-10%	11%-20%	21%-40%	41%-60%	61%-80%	81%-100%	
1986-87		2%	6%	14%	14%	25%	21%	18%	51
1990-91		6%	7%	10%	17%	17%	30%	13%	60
1994-95		0%	7%	10%	19%	18%	21%	25%	84
1998-99		0%	2%	5%	13%	15%	18%	37%	60

TABLE 15. Distribution of Medical Schools on Total Dollars in Commercial Support of Courses and Percent of Revenue from Commercial Support

Reporting Year	$0	$1 to $20,000	$20,001 to $60,000	$60,001 to $100,000	$100,001 to $300,000	$300,001 to $600,000	$600,001 to $1 million	>$1 million	Total Schools
		a. Total Dollars from Commercial Support							
1986-87	5%	28%	43%	11%	13%	0%	0%	0%	44
1990-91	9%	8%	21%	11%	43%	9%	0%	0%	47
1994-95	0%	1%	12%	23%	29%	24%	8%	3%	81
1998-99	0%	3%	11%	3%	31%	14%	16%	22%	58
		b. Percent of Revenue from Commercial Support							
		1% to 10%	11% to 20%	21% to 40%	41% to 60%	61% to 80%	81% to 100%		
1986-87		35%	20%	30%	8%	5%	2%		40
1990-91		17%	36%	33%	5%	9%	0%		42
1994-95		19%	24%	33%	18%	6%	0%		72
1998-99		6%	11%	50%	22%	9%	2%		54

the percent of an institution's courses with commercial support (Table 14, part b.) is more readily interpretable. In 1998-99 more than half of the medical schools reported that 60% or more of their CME courses received commercial support. Comparing the number of courses receiving support across the time periods, the trend is for a higher percentage of courses to receive commercial support. This is more clearly evident in the second section of Table 18. Across the 25th, 50th, and 75th percentiles, the 50th percentile (median) of courses receiving support has increased from 50% to 70%, with the biggest increase occurring in recent years.

What is the magnitude of the financial support? Institutions were asked to take into account financial support paid both to the CME unit and directly to faculty for course expenses and report (a) the approximate total contributed by commercial companies to support courses oriented to external physicians and (b) the approximate percentage of the annual course revenue represented by this dollar amount.

The upper half (part a.) of Table 15 shows that medical schools vary widely on the total dollars received from commercial support. The amounts range from $0 to $5.2 million. Comparing the dollars received across the time periods, an appreciable increase is evident across time. The magnitude of the change is clearer in the third section of Table 18, which shows the 25th, 50th, and 75th percentiles for the years. The reported total dollars approximately doubles between each four year period. However, the circumstance underlying the reported increases may differ across the periods. The amount of commercial support going to CME was commonly recognized to be increasing substantially during the late 1980's and the increase from 1986-87 to 1990-91 probably reflects a substantial increase in real funds. In the early 1990's stricter standards for documenting all commercial support were implemented and a substantial amount of previously unreported support began to be documented. At the same time, the amount of commercial support was commonly recognized not to be increasing much. The increase in reported dollars from 1990-91 to 1994-95 is probably predominantly an increase in the amount of documented commercial support rather than an increase in the actual amount of commercial support received. The increase from 1994-95 to 1998-99 is probably an increase in the actual amount of support.

The potential impact of commercial support on a medical school's CME program depends more on its relative proportion of overall income than on the absolute dollar amount of support. The lower half (part b.) of Table 15 shows the distribution of medical schools on the percent of course revenue received from commercial support. The substantial majority of medical schools obtain at least 20% of their course revenue from commercial support. Commercial support constitutes the majority of income (>60%) at 11% of medical schools. While commercial support is generally not the biggest source of revenue, it appears to be a very important secondary source at most medical schools. Comparing the percent of course revenue from commercial support across the time periods, a meaningful recent increase is evident. The magnitude of change is clearer in the fourth section of Table 18, which shows the 25th, 50th, and 75th percentiles for the years. The 50th percentile (median) for percent of revenue from commercial support was stable at about 20% until the recent increase to 35%.

In examining current views of CME directors regarding trends (Table 10), the biggest change is the increase in financial support from commercial companies. This perception is consistent with the changes reported in number and percent of courses receiving support and in actual dollars and percent of course revenue that these dollars represent.

Course dependence on commercial support. What would happen if this commercial support were removed? Some courses depend on commercial support as the only meaningful

source of revenue. For some courses commercial support may not be the biggest revenue component, but it is a

TABLE 16. Distribution of Medical Schools on Number of Courses Supported "Solely" by One Commercial Company

Reporting Year	a. Number of "Solely" Supported Courses: 0	1-5	6-10	11-20	>20	Total Schools
1994-95	41%	32%	14%	9%	4%	84
1998-99	13%	36%	22%	14%	15%	61
	b. Percent of Courses that are "Solely" Supported 0%	1%-5%	6%-10%	10%-20%	21-50%	>50%
1994-95	42%	28%	11%	8%	9%	2%	82
1998-99	14%	16%	`24%	19%	16%	11%	56

TABLE 17. Distribution of Medical Schools on Number of Courses That Would Not Have Been Held (and External Attendance) If No Commercial Support

Reporting Year	a. Number of Courses Not Held 0 Schools	1-5	6-10	11-20	20-50	>50	Total
1986-87	27%	32%	22%	14%	5%	0%	37
1990-91	16%	14%	34%	20%	14%	2%	44
1994-95	12%	29%	18%	22%	18%	1%	77
1998-99	9%	11%	19%	22%	26%	13%	54
	b. Number of External Attendees 0	1 to 500	501 to 1,000	1,001 to 2,000	2,001 to 4,000	>4000	
1986-87	28%	42%	5%	22%	3%	0%	36
1990-91	10%	36%	34%	12%	8%	0%	40
1994-95	11%	35%	18%	24%	12%	0%	72
1998-99	2%	23%	13%	27%	18%	17%	48

necessary component for the course to be viable. For yet other courses, commercial support provides enhancements in quality (more guest faculty, more expensive promotional materials, more expensive food), but the course would still be viable without these enhancements.

The 1994-95 survey was the first to ask for the number of CME courses oriented to external physicians that were "solely" supported by one commercial company (i.e. all or most of the costs were paid by one company with participants paying either no fee or a token fee). The response is presented in Table 16, part a. Approximately half of the medical schools sponsored more than 5 "solely" supported courses. Table 18 presents the 25th, 50th, and 75th percentiles of the distribution. Over the past four years the trend to offering more solely supported courses is indicated by the shift in the 50th percentile (median) for medical schools from 1 course to 6 courses.

Again, it is important to interpret the numbers in the context of the size of the school's overall CME program. Part b. of Table 16 presents the percentage of the school's total number of courses oriented to external physicians that were "solely" supported. For almost half of the schools, "solely" supported courses constitute less than 10% of their course offerings, with solely supported courses constituting the majority of CME courses at 11% of medical schools. The increase in percent of courses that are solely supported is more clearly presented in Table 18, which shows the 25th, 50th, and 75th percentiles of the distribution. In the past four years, the 50th percentile (median) percent of courses that are solely commercially supported increased from 2% to 9% of a school's CME offerings.

What if there were no commercial support? In addition to "solely" supported courses not having occurred, a number of other courses depend on commercial support as a vital component of revenue. A rough estimate of the impact of commercial support on CME programming was obtained by asking: "If no financial support from commercial companies had been available in 1998-99, what is your estimate of (a) the number of courses oriented to external physicians in 1998-99 that would not have been held and (b) their attendance?"

TABLE 18. Distribution (Quartiles) of Medical Schools on Extent of Commercial Support for Courses Oriented to External Physicians

	Reporting Year	25th Percentile	50th Percentile	75th Percentile	Total Schools
Number of Courses	1986-87	9	14	25	51
Receiving Support:	1990-91	12	23	46	58
	1994-95	16	26	44	86
	1998-99	21	38	76	58
Percent of Courses	1986-87	23%	50%	70%	51
Receiving Support:	1990-91	25%	50%	70%	60
	1994-95	25%	59%	81%	84
	1998-99	49%	70%	90%	60
Total Amount of	1986-87	$20,000	$41,000	$75,000	42
Commercial Support Funds:	1990-91	$53,000	$115,000	$198,000	43
	1994-95	$88,000	$186,000	$383,000	82
	1998-99	$147,000	$309,000	$984,000	58
Percent of Course Revenue	1986-87	8%	20%	30%	40
from Commercial Support:	1990-91	12%	20%	33%	42
	1994-95	10%	21%	35%	79
	1998-99	25%	35%	54%	54
Number of Courses	1986-87	(not collected)			
Supported "Solely"	1990-91	(not collected)			
by One Company:	1994-95	0	1	6	84
	1998-99	2	6	14	61
Percent of School's	1986-87	(not collected)			
Courses Supported "Solely"	1990-91	(not collected)			
by One Company:	1994-95	0%	2%	10%	82
	1998-99	4%	9%	23%	56
If No Support, Number	1986-87	0	3	8	37
of Courses Not Held:	1990-91	4	10	15	44
	1994-95	2	8	18	77
	1998-99	6	17	38	54
Number of Attendees	1986-87	0	200	900	36
at Courses Not Held	1990-91	250	772	1,000	40
if No Support	1994-95	121	650	1,500	72
	1998-99	552	1,500	2,800	48

Responses to the number of courses that would not have been held are presented in the upper half (part a.) of Table 17. Without commercial support, more than 10 courses would not have been held at the majority of medical schools. Comparing the distributions across the time periods, an increase is evident in the number of courses that would not have been held. The extent of increase is clearer in the next-to-last section of Table 18, which presents the 25th, 50th, and 75th percentiles for the time periods. The trend shows that the biggest change is the increase over the past four years in number of courses that would not have been held.

The number of attendees at courses that would not have been held is presented in the lower half (part b.) of Table 17. At the majority of medical schools the cancellation of the courses would affect more than 1,000 attendees. The changes are

across time are clearer in the last section of Table 18, which presents the 25th, 50th, and 75th percentiles for the time

TABLE 19. Level of Commercial Support for Media Delivered CME Activities at Medical Schools

Type of Media Delivered CME Activity	Year	Total # of Activities	# of Activities with This Level of Support				Total Schools
			None*	Some	"Vital"	Total	
Telephone conf., single session	1994-95	115	35	7	31	42	53
	1998-99	99	3	64	8	24	56
Telephone conf., multiple session	1994-95	98	28	6	4	59	86
	1998-99	294	239	1	0	54	56
Televised conf., single session	1994-95	97	68	11	13	5	87
	1998-99	87	4	52	30	1	56
Televised conf., multiple session	1994-95	49	27	7	14	1	81
	1998-99	36	1	35	0	0	56
Internet live, single session **	1998-99	9	0	3	1	5	56
Internet live, multiple session **	1998-99	5	2	1	0	2	56
Tutorial or traineeship **	1998-99	23	20	0	0	3	56
Written self-study (inc. journals)	1994-95	205	118	12	8	67	82
	1998-99	211	15	6	71	119	56
Audio self-study	1994-95	54	34	9	2	9	81
	1998-99	21	1	1	15	4	56
Video self-study	1994-95	102	65	10	15	12	81
	1998-99	75	7	55	0	13	56
Computer, disk self-study	1994-95	23	18	2	2	1	80
	1998-99	12	4	1	3	4	56
Computer, Internet self-study	1994-95	18	16	1	0	1	79
	1998-99	67	10	3	43	11	56

* Blanks were coded as no support ("none"), so the number of "none" responses may be artificially increased.

** Not asked in 1994-95

periods. A substantial increase in number of participants that would be affected is evident across the last four year period.

Support for "media delivered" CME activities. The 1994-95 survey was the first to ask about the extent of commercial support for CME activities involving special communication media or storage. The results are presented in Table 19. This table presents the total number of each type of activity summed across all medical schools. Each school indicated how many of each type of activity received four levels of support: none, some, "vital" (i.e. not total, but no activity without support), and total support. The number of each type of activity receiving each level of support was then summed across all medical schools.

The first entries concern live CME activities that were simultaneously transmitted to other locations. The extent of commercial support for telephone conferences differs by whether they are single session or multiple session. Most single session telephone conferences received commercial support, while most multiple session conferences did not. Across the four years, commercial support for both types of telephone conferences decreased.

A majority of televised conferences, both single session and multiple session, receive commercial support. Across the four years, commercial support for both types of televised conferences increased.

Most internet broadcast (live) conferences, both single session and multiple session, receive commercial support.

Most tutorial and traineeship activities do not receive commercial support.

The last five entries concern CME activities developed as enduring materials for self-study. The pattern is similar for almost all of the formats. Most self-study in written, audio, computer disk and computer internet forms is dependent on commercial support. The extent of dependence is greater than four years ago. Video self-study tends to receive some commercial support, but the majority is not dependent on it.

TABLE 20. Distribution of Medical Schools on Frequency of Use of Commercial Support for Specific Activities

	Reporting Year	How Often Supported				Mean [1-4]	Total Schools
		Never [1]	Seldom [2]	Sometimes [3]	Often [4]		
General Grant to Course:	1986-87	2%	15%	28%	55%	3.4	54
	1990-91	0%	5%	20%	75%	3.7	60
	1994-95	2%	0%	9%	89%	3.9	88
	1998-99	2%	2%	10%	86%	3.8	61
Speakers (Honoraria	1986-87	4%	11%	31%	54%	3.4	54
and Travel):	1990-91	8%	10%	31%	51%	3.3	59
	1994-95	12%	19%	39%	30%	2.9	88
	1998-99	19%	20%	35%	26%	2.6	62
Food / Refreshments	1986-87	8%	31%	50%	11%	2.6	54
for Participants:	1990-91	17%	28%	40%	15%	2.5	58
	1994-95	26%	39%	27%	8%	2.2	88
	1998-99	24%	28%	30%	18%	2.4	62
Dinner for Course Faculty:	1986-87	17%	41%	37%	5%	2.3	54
	1990-91	29%	38%	21%	12%	2.2	59
	1994-95	42%	37%	18%	3%	1.8	88
	1998-99	44%	30%	21%	5%	1.9	62
General Grant to	1986-87	44%	30%	13%	13%	2.0	54
CME Unit	1990-91	36%	33%	10%	21%	2.2	58
	1994-95	37%	41%	10%	12%	2.0	86
	1998-99	43%	40%	9%	8%	1.8	60
Auditorium Rental:	1986-87	63%	22%	13%	2%	1.5	54
	1990-91	55%	22%	12%	10%	1.8	58
	1994-95	65%	23%	11%	1%	1.5	88
	1998-99	57%	23%	18%	2%	1.6	61
Social Events (new item):	1998-99	50%	32%	15%	3%	1.6	60
Travel Expenses	1986-87	54%	22%	15%	9%	1.8	54
of Participants:	1990-91	88%	5%	4%	3%	1.2	58
	1994-95	93%	5%	2%	0%	1.1	88
	1998-99	96%	2%	2%	0%	1.1	62

The extent to which video self-study activities receive commercial support has increased over the last four years.

Use of commercial support. How are financial contributions from companies utilized? Table 20 indicates several specific activities frequently supported with commercial funds and the responses of medical school CME units to how often the type of activity is supported with commercial funds.

When support is provided, it is most often provided as a general grant to the course. The second and third most frequent designated uses are for speaker's expenses (honoraria and travel) and for food and refreshments for course participants. Infrequently support is specifically designated for dinners for course faculty, for auditorium rental, or as a general grant to the CME unit. Support is almost never designated for travel expenses of participants.

Comparing the distributions across the time periods, the rankings of the frequency with which support is designated across specific types of activities are fairly stable. Comparing the means within a specific type of activity, the only increase

is in the frequency with which support is designated as a general grant to a course. The specific designation of support

TABLE 21. Distribution of Medical Schools on
Policies Concerning Commercial Support for CME Activities

	Year (Reported in February)	Institutional Stand on Policy			Total Schools
		Yes	No	Not Considered	
Financial Support from	1988	94%	3%	3%	58
Company is Accepted:	1992	95%	3%	2%	64
	1994	99%	1%	0%	89
	2000	98%	2%	0%	62
Courses with Commercial	1988	53%	34%	13%	55
CME Production Companies	1992	48%	40%	12%	63
Will Be Supported:	1994	54%	28%	18%	88
	2000	60%	25%	15%	60
All Funds and Transactions	1988	51%	44%	5%	57
Must Pass through CME	1992	50%	45%	5%	64
Unit:	1994	67%	32%	1%	89
	2000	54%	44%	2%	62
University Honoraria Guide-	1988	47%	40%	13%	57
lines Take Precedence	1992	50%	45%	5%	63
over Company's Guidelines:	1994	60%	26%	14%	87
	2000	50%	36%	14%	59
Courses Must Have	1988	50%	36%	14%	56
at Least a Token Fee:	1992	48%	38%	14%	63
	1994	55%	31%	14%	85
	2000	44%	45%	11%	62
Company Can Specify the	1988	18%	54%	28%	57
Only Individuals Invited:	1992	11%	73%	16%	63
	1994	13%	71%	16%	86
	2000	9%	86%	5%	62

to go to more specific uses has tended to decrease. The payment of travel expenses for participants (a practice that national guidelines now view as inappropriate under most circumstances) decreased appreciably after the first time period and remains rare.

Institutional policies regarding commercial support. Another series of questions addressed institutional policies concerning financial support from commercial companies. As indicated in Table 21, virtually all medical schools indicated they will accept financial support from commercial companies. However, policies regarding the handling of funds and associated arrangements vary somewhat across medical schools. About half of the medical schools have policies that: courses involving communication companies may be sponsored, all funds and transactions pass through the CME unit, university honoraria guidelines take precedence over company guidelines, and courses must have at least a token fee. Few medical schools will sponsor a program where a commercial company can specify the only individuals to be invited.

Comparing the responses across the time periods, relatively modest change has occurred concerning these policies. The changes over the past four years generally reflect a loosening of policies at some schools: fewer schools requiring that funds pass through the CME unit, that courses have a token fee, and that university honoraria guidelines take precedence.

The preceding items were included on previous surveys. The 2000 survey asked some additional questions related to funding and arrangements with commercial companies.

Credit recording fees for commercially funded self-study activities. Many institutions obtain commercial funding to develop self-study activities and distribute them at no charge, but the institution charges a fee for recording and maintaining

a record of an individual's participation. Sixty percent of the schools indicated that they offer commercially

TABLE 22. Distribution of Medical Schools on Credit Recording Fee Charged for Commercially Funded Self-Study Activities, When Fee Charged

Fee	$0	$5	$10	$15	$20	$25	$30	$35	N
% Schools	3%	3%	19%	19%	34%	16%	3%	3%	32

TABLE 23. Distribution of Medical Schools on Some Issues with Commercial Companies

Commercial companies' administrative processes during the last year resulted in:	Seldom [1]	Some-times [2]	Often [3]	Usually [4]	Always [5]	Mean [1-5]	Total School
Their timely signing of letters of agreement	5%	16%	34%	40%	5%	3.2	58
Their paying funds in a timely manner	7%	12%	29%	47%	5%	3.3	59
It being easy for us to compose letters requesting funds	4%	16%	31%	45%	4%	3.3	51

TABLE 24. Distribution of Medical Schools on Number of Commercially Funded "Satellite" Meetings Held in Conjunction with Meetings of National Specialty Societies

Number of "satellite" meetings	0	1-5	6-10	11-20	
Percent of medical schools	48%	42%	5%	5%	58 schools

TABLE 25. Distribution of Medical Schools on Issues about "Satellite" Meetings

To what extent :	Not at All [1]	A Little [2]	Some-what [3]	A Lot [4]	Mean [1-4]	Total Schools
Did funding of satellite meetings reduce funding for regional CME activities?	76%	9%	6%	9%	1.5	33
Were communication companies responsible for the management of satellite meetings?	17%	25%	16%	42%	2.8	36
Did you have problems with the management of satellite meetings?	25%	56%	11%	8%	2.0	36

funded self-study activities. Table 22 presents the distribution of these medical schools on the usual fee charged. The fees vary widely, with the typical (median) fee being $20.

Administrative issues and commercial support. Table 23 presents the experience of schools on some operational issues with commercial companies. Although the wider distribution indicates some variation in experience, the majority of schools find that commercial companies are "often" or "usually" timely in signing letters of agreement, timely in paying funds, and have processes making it easy for the CME unit to compose letters requesting funds from the company.

"Satellite" meetings. A recent trend is for commercial companies to fund the production of "satellite" meetings, i.e. short CME activities held in conjunction with the meetings of national specialty societies. Table 24 shows that half of medical schools sponsored a "satellite" meeting last year, although most of these schools only sponsored a few of these meetings. Table 25 presents information on some issues about "satellite" meetings. The majority of the schools sponsoring "satellite" meetings found that these meetings did not reduce funding for regional CME activities. Communication companies were involved in the management of the substantial majority of satellite meetings, typically handling most or all of the management. The majority reported having

problems with the management of “satellite” meetings, although this was usually only “a little.”

TABLE 26. Distribution of Medical Schools on Issues about Working with Communication Companies

In working with communication companies to what extent do you have problems with:	Not at All [1]	A Little [2]	Some-what [3]	A Lot [4]	Mean [1-4]	Total Schools
Short time constraints?	14%	42%	20%	14%	2.4	43
Following approval processes?	30%	28%	33%	9%	2.2	43
Budget control?	29%	40%	22%	9%	2.1	42
Faculty contacts and messages? 43		35%	42%	16%	7%	2.0

Note: 70% of 62 medical schools work with communication companies.

TABLE 27. Distribution of Medical Schools on the Level of Involvement Required from Own Faculty before Sponsoring a CME Activity with a Communication Company

Would your school consider sponsoring a CME activity if a member of your faculty:	No	Yes	Total Schools
Is the activity director or co-director?	0%	100%	43
Is on the presenting faculty of the activity?	19%	81%	43
Reviews the planned activity?	47%	53%	43
Is not involved in the content planning, delivery, or review?	88%	12%	43

Communication Companies

As a special topic, the 2000 survey included several questions about the experience of CME units working with communication companies. Communication companies are for profit businesses that seek funding from manufacturers of health care products and services (i.e. "commercial companies") to develop and produce continuing education activities for health care professionals. Communication companies typically have special expertise in logistical and technical areas, e.g., advertising, journal publication, communication technology, and meeting planning. Many of these companies seek to partner with accredited CME providers, with the accredited CME provider overseeing the activity and the company administering it.

Of the 62 schools responding, 74% indicated that they currently work with communication companies. Table 26 presents the responses of the medical schools working with communication companies regarding some administrative issues. The distributions of the answers to the four questions are fairly wide spread, indicating a variety of experiences. Most typically, medical schools have a little problem with short time constraints, the company following approval processes, budget control, and faculty contacts and messages.

Schools vary on the level of content involvement required from their own faculty before the school will sponsor a CME activity with a communication company. Table 27 indicates the level of involvement by a school's faculty before the school will sponsor a CME activity. Schools tend to be similar in sponsoring activities when a faculty member is the activity director or on the presenting faculty and to be similar in tending not to sponsor activities having no faculty involvement. Schools differ most on whether a faculty member reviewing an activity is sufficient content involvement to sponsor an activity.

The final question concerned whether CME units like to work with communication companies. The responses are presented in Table 28. Among those schools working with communication companies, the variation in responses is appreciable, with the most frequent response being slight agreement and the second most frequent response being slight disagreement. Note that the views of CME units not working with communication companies are not represented in Table 28.

Paying Faculty Honoraria

Institutions vary in their views regarding who can set faculty honoraria. As background, item 5.a of the Standards for Commercial Support of CME (unchanged in the revision to System 98) states that (1) *funds from a commercial source*

should be paid to the accredited provider and that (2) *no other funds from a commercial source should be paid to the director of the activity, faculty, or others involved with the supported activity.* Based on this Standard, the ACCME for several years emphasized that only the accredited provider should pay

TABLE 28. Distribution of Medical Schools* on Liking to Work with Communication Companies

	Disagree Strongly (1)	Disagree Some-what (2)	Neutral/ No Opinion (3)	Agree Some-what (4)	Agree Strongly (5)	Mean [1-5]	Total Schools
Our CME unit likes to work with communication companies:	7%	26%	17%	41%	9%	3.2	42

* The questionnaire branching allowed only medical schools working with communication companies to respond to this question.

TABLE 29. Distribution of Medical Schools on Issues about Paying Honoraria

Regarding the payment of honoraria to faculty, accredited providers should be able routinely to delegate this responsibility to:	Disagree Strongly (1)	Disagree Some-what (2)	Neutral/ No Opinion (3)	Agree Some-what (4)	Agree Strongly (5)	Mean [1-5]	Total Schools
No other organization (i.e. no delegation)	36%	25%	0%	8%	31%	2.7	62
Joint sponsors of an activity	5%	7%	3%	49%	36%	4.1	61
Communication companies assisting with logistical aspects of the activity	41%	10%	2%	32%	15%	2.7	59
Speaker's bureaus funded by commercial companies	64%	15%	8%	6%	7%	1..8	61
Commercial companies (e.g., drug company)	84%	6%	2%	0%	8%	1.4	61

honoraria to faculty unless unusual extenuating circumstances are present. In early 1999 the ACCME modified this stance by adopting the following policy (99-A-14): *The accredited provider may delegate the responsibility for receiving and disbursing funds from educational grants to an educational partner. However, the letter of agreement regarding the grant must be between the accredited provider and the commercial supporter and the accredited provider must maintain and be able to produce as documentation a full accounting of the funds.* Some individuals feel that accredited sponsors should not be able to delegate payment of honoraria using commercial funds. Others agree with the new ACCME policy allowing delegation to an "educational partner," but disagree on types of relationships that constitute an "educational partner."

Table 29 presents responses on the delegation of the responsibility regarding the payment of honoraria. The question of generally not allowing delegation produced extreme variation, with substantial numbers of people agreeing with no delegation and substantial numbers believing payment can be delegated. Interestingly, a substantial majority agreed that payment could be delegated to a joint sponsor of an activity. Variation is again fairly extreme regarding delegating faculty payment to a communication company, with the biggest group strongly disagreeing. Agreement was fairly high that payment should not be delegated to speaker's bureaus funded by drug companies or to drug companies.

Faculty Development and CME

Is faculty development on CME topics available and if so, in what formats? Table 30 presents information regarding making effective CME presentations, ethical behavior and standards regarding commercial support, CME activity planning, and CME administration. Individual consultation and written materials are available on all four topics at the substantial majority of medical schools. Scheduled group instruction is available at one-third to one half of the schools, depending on the topic.

Regularly Scheduled Conferences

Several CME units have expressed concern about the CME administrative work load associated with regularly scheduled conferences (e.g., grand rounds). The 2000 survey asked several questions to understand better how CME units handle this work load. The responses are presented in Table 31.

Almost all schools designate credit for regularly scheduled conference series. The majority review complete documentation annually, while one-third review

documentation much more frequently. Schools vary widely on the extent to which topics and speakers for individual sessions have to be documented before credit is designated: half require little to no detail and half require detail for most or all of the sessions.

TABLE 30. Distribution of Medical Schools on Faculty Development and CME

Does your medical school provide faculty development in the formats to the right on the following topics?	Individual Consultation When Requested		Written Materials Distributed		Scheduled Group Instruction		Total Schools
	No	Yes	No	Yes	No	Yes	
Effective CME presentations	31%	69%	41%	59%	51%	49%	59
Ethical behavior and CME standards for commercial support	13%	87%	25%	75%	70%	30%	57
CME activity planning and CME curricula development	10%	90%	16%	84%	69%	31%	58
CME administration (e.g., documentation requirements, ACCME accreditation process, types of CME credit)	12%	88%	18%	82%	56%	44%	55

TABLE 31. Distribution of Medical Schools on Issues Associated with CME Administration of Regularly Scheduled Conferences

Item	Distribution				Total Schools
		No	Yes		
Does your institution designate category 1 credit for regularly scheduled conference series such as grand rounds?		5%	95%		62
	Each Session	Every 6 Months	Annually	Every 2 Years	
How frequently do you review complete documentation for a conference series?	14%	20%	59%	7%	59
	None	Few Examples	Majority of Sessions	All Sessions	
For a regularly scheduled conference, to what extent are topics and speakers for individual sessions documented before credit is designated?	20%	28%	28%	24%	59
For sessions with regularly scheduled conferences, which unit is typically responsible for performing:		CME Unit	Content Unit		
Obtain disclosure information from faculty		10%	90%		59
Arrange for payment of honoraria of faculty		22%	78%		58
Prepare evaluation reports about the CME activity		36%	64%		58
Maintain records of CME attendance		69%	31%		58

Typically the content unit obtains disclosure information from faculty and arranges payment of honoraria for faculty. While schools assign the responsibilities differently, the content unit is more likely to prepare evaluation reports about the CME activity and the CME unit is more likely to maintain records of CME attendance.

ACCME System 98

ACCME revised the "Essentials, Guidelines, and Standards" and nationally accredited CME providers are now accountable for implementing and following the revised "Essentials Areas and Standards." The new "Essentials Areas and Standards"

are often referred to as “System 98”. Table 32 presents responses concerning some issues regarding “System 98.”

TABLE 32. Distribution of Medical Schools on Issues with ACCME System 98

Item	Distribution						Total Schools
	Not at All	A Little	Some-what	Fairly Well	Very Well	Mean [1-5]	
How well do you feel that you understand System 98?	5%	3%	20%	44%	28%	3.9	61
Compared to the previous version of the Essentials and Standards, how is System 98 affecting:	Decrease A Lot	Decrease A Little	No Change	Increase A Little	Increase A Lot	Too Early to Tell	
Your administrative work load?	0%	2%	42%	19%	12%	25%	57
The quality of your CME activities?	0%	0%	63%	11%	1%	25%	57

About three-quarters of the respondents feel that they understand System 98 fairly to very well. A quarter of the respondents feel that it is too early to tell the effects of System 98. The other three-quarters of respondents tend to feel that System 98 will involve "no change" to "a slight increase" on administrative workload and "no change" on the quality of CME activities.

Medical Schools and ACCME

CME providers frequently discuss issues concerning the functions and performance of ACCME. Table 33 presents responses to questions concerning some of these issues.

Questions are sometimes raised about how well SACME and its interests are represented on the ACCME Council. The first section of Table 33 presents responses concerning how well each parent organization represents SACME's interests. The most striking finding is that about half of the respondents (i.e. SACME voting members from medical schools) feel they do not know enough about the parent organization's activities on the ACCME Council to respond. When only the responses expressing an opinion are considered, the AAMC is viewed as representing SACME's interests "somewhat" (3.1) and other organizations are viewed as representing SACME's interests "a little" or less. The rankings correspond to the presence of SACME members on the Council. Two of the three Council members from AAMC (Nancy Bennett, Ph.D. and Linda Casebeer, Ph.D.) and one of the Council members from the AMA (Robert Raszkowski, M.D., Ph.D.) are SACME members.

Another set of questions asked if SACME and the Alliance for CME should each have a directly appointed representative on the ACCME Council. Responses were fairly widely distributed, with the average "agreeing somewhat" that these two organizations should be represented.

When asked if the ACCME represents the best interests of medical schools, the fairly widely dispersed responses were slightly below neutral. Respondents disagreed with disbanding ACCME. The majority agreed that a new approach should be developed for the accreditation of medical schools' CME programs.

AAMC and the Educational Continuum

Another group of questions asked about respondent's views concerning AAMC and the continuum of medical education. The responses are presented in Table 34.

When asked if the respondent (SACME voting member for the medical school) is a member of the CME section of the Group on Educational Affairs, the majority said yes, although almost 20% are uncertain. When asked about involvement in undergraduate and graduate medical education, a number of types of involvement were indicated by a meaningful number of individuals (see Table 34). Overall, the over half have some involvement in either or both undergraduate and graduate medical education. Most agreed that the education of practicing physicians and that the office of CME are both integral parts of the educational mission of their medical schools. Most agree strongly that lifelong learning skills should be taught at all levels of medical education.

New SACME Membership Category

The Society currently has seven membership categories (voting, associate, emeritus, continuing, student, corresponding/international, and honorary life members). Occasionally individuals interested in CME and CME research inquire about becoming members of the Society, but they do not qualify because they are either not affiliated with a medical school or they are affiliated with a medical school that does not have a SACME voting member to nominate them. Examples of individuals who might share interests in academic CME include individuals based at a teaching hospital, an osteopathic school of medicine, or one of the National Institutes of Health. A membership category could be added for these individuals. (If a membership category were created, it is likely that the Board of Directors would review and approve applicants to this category, as they currently do

for applicants to the corresponding/international member category.)

Table 33. Distribution of Medical Schools on Some Issues Regarding ACCME

Issue	Distribution					Mean	Total School
How well do you feel that SACME's interests are represented at the ACCME Council by each parent organization:	Not at All (1)	A Little (2)	Some-what (3)	Very Well (4)	[Don't Know]	[1-4]	
Assoc. of American Medical Colleges	0%	17%	21%	20%	42%	3.1	60
American Medical Association	13%	20%	12%	10%	45%	2.3	60
Assoc. for Hospital Medical Education	18%	7%	17%	5%	53%	2.2	60
American Board of Medical Specialties	20%	8%	12%	7%	53%	2.1	62
Council of Medical Specialty Societies	20%	5%	8%	7%	60%	2.0	60
Federation of State Medical Boards of the U.S.	23%	9%	5%	3%	60%	1.7	60
American Hospital Association	30%	3%	7%	3%	57%	1.6	60
The following organizations should have a directly appointed representative on the ACCME council:	Disagree Strongly (1)	Disagree Some-what (2)	Neutral/ No Opinion (3)	Agree Some-what (4)	Agree Strongly (5)	[1-5]	
SACME	12%	7%	15%	20%	46%	3.8	60
Alliance for CME	15%	2%	25%	31%	27%	3.5	60
As presently operating, the ACCME:							
Represents the best interests of medical schools	10%	41%	17%	25%	7%	2.8	59
Should be disbanded:	43%	30%	15%	7%	5%	2.0	56
A new approach should be developed for the accreditation of medical schools' CME programs	12%	20%	10%	31%	27%	3.4	59

Table 35 presents the responses to whether a new membership category should be created that would include these individuals. The majority of the respondents agree.

Summary

CME units and personnel share an overall mission to ensure that high quality CME programs are developed and produced at medical schools. The results of the biennial surveys continue to demonstrate the diversity across medical schools in the types and amounts of programming and in organizational and operational arrangements for CME units and CME personnel. The intent of the survey is not to produce an overall integrated view of CME units and their activities, but to highlight areas and issues of particular interest. Summarized below are some of the major findings regarding topics in this year's survey.

Programs and attendees. Regarding live, in person courses for external physician attendees, in 1998-99 the typical (median) medical school produced 67 courses with 754 hours of credit and had an annual attendance of 3,314 physicians and 1,983 other participants. Each of these numbers is an increase over previous years. Although medical schools vary widely on the actual numbers, a general increase is evident.
Other forms of CME vary in their prevalence across medical schools. The majority of medical schools arrange presentations at county medical societies and local hospitals. Relatively few medical schools broadcast live conferences by telephone, television, or Internet. Just under half of medical schools offer individual tutorials or traineeships, with a trend across years for fewer schools to offer them. Regarding self-study CME activities, most medical schools offer self-study activities, with the majority offering them in written form. About half offer Internet self-study, while a minority offer self-study in video, computer disk, or audio formats. Across years, there is a trend for an increasing number of schools to produce self-study materials, with a recent increase in written materials and their use. Computer based materials – particularly by Internet -- also increased, but schools offering Internet CME typically produced only a few (1 – 10) of these activities and relatively few participants (1 – 200) used them at any school.

This year's survey asked about CME activities oriented primarily to "internal" physicians, i.e. physicians who are faculty of the medical school. Virtually all schools designate credit for some ongoing multiple session internal activities

such as grand rounds, but schools vary widely on the number. The majority of schools do not designate credit for single occasion internal activities. Over the past two years there is a slight trend to designate fewer internal activities for credit.

TABLE 34. Distribution of Medical schools on Some Issues Regarding Undergraduate and Graduate Medical Education

Issue	Distribution						Total School
Are you (institution's SACME voting member) a member of the CME section of the Group on Educational Affairs of the AAMC?	No 18%	Yes 64%	[Uncer-tain] 18%				62
Are you involved in undergraduate and graduate medical education in the following ways:	Undergraduate Medical Ed.		Graduate Medical Ed.				
	No	Yes	No	Yes			
Hold direct supervisory roles	84%	16%	77%	23%			60
Serve on one or more curriculum related committees	64%	36%	73%	27%			60
Teach	57%	43%	65%	35%			59
Participate in educational research or evaluation	61%	39%	62%	38%			58
Overall: involved in any of the above ways	42%	58%	45%	55%			60
	Disagree Strongly (1)	Disagree Some-what (2)	Neutral/ No Opinion (3)	Agree Some-what (4)	Agree Strongly (5)	Mean [1-5]	
The education of practicing physicians is an integral part of the educational mission of my medical school	0%	6%	5%	26%	63%	4.5	62
The Office of CME is an integral part of the educational mission of my medical school	0%	14%	0%	31%	55%	4.3	62
Lifelong learning skills should be taught in:							
Undergraduate medical education	0%	2%	2%	17%	79%	4.7	61
Graduate medical education	0%	0%	2%	18%	80%	4.8	61
Continuing medical education	2%	0%	2%	16%	80%	4.7	61

TABLE 35. Distribution of Medical Schools on a New SACME Membership Category

	Disagree Strongly (1)	Disagree Some-what (2)	Neutral/ No Opinion (3)	Agree Some-what (4)	Agree Strongly (5)	Mean [1-5]	Total Schools
A membership category in SACME should be created for individuals interested in academic CME who do not otherwise qualify for membership	5%	5%	23%	37%	25%	3.7	62

Regarding activities for which credit was not designated, but probably could be if "paper work" requirements were performed, the majority of schools had a few additional internal activities that would be converted from not-for-credit to for-credit.

Course fees. The usual fee per credit hour ranges widely across medical schools. Fees for courses at the institution's primary location (median of $16/credit hour) have increased slightly. Fees for courses at "pleasure" locations (median of $25/credit hour) also increased slightly.

Current trends. The overall summary of current trends is that the largest changes are increases in the number of courses, in the commercial support for courses, and in the quality of courses and for slight decreases in the time between registering and the course date. For the other items, the overall trend is close to no change, but with some individual

institutions experiencing changes in both decreasing and increasing directions.

When looking at trends across years, the biggest change is the shift toward increasing commercial support. The trends across time on the other measures have been generally similar for several years. Sustained trends for appreciable increases are in the quality of courses and in the number of courses offered. Sustained trends for slight increases are in faculty interest in participating in both the school's CME and other sponsor's CME and in the number of external physicians per course. A sustained trend for little change is found for attendance at courses at "pleasure" locations. A sustained trend for slight decreases is found for financial support for CME from the university and for time between registering and the course date.

Research in CME units. Research is being performed in 31% of medical school CME units. About one-quarter to one-third of medical schools are involved in each of the following: CME unit personnel doing CME research based in other units, personnel based in other units doing CME research, CME personnel doing research on other levels of medical education, and CME personnel doing research on topics other than medical education. The involvement of CME units in research increased over previous years, including the typical senior staff time devoted to it and the level of funding obtained for it.

Financial involvement of commercial companies. While medical schools vary widely in the number of courses, the typical (modal) medical school received support for 38 courses, which represents 70% of the school's CME activities. The typical school received $309,000 in support, representing 35% of the schools' course revenue. All of these are substantial increases over the amounts reported four years ago.

The typical school offered six courses supported solely by one company, representing 9% of the school's courses. If commercial support were no longer provided, the typical school would no longer hold 17 courses, representing 25% of the school's courses and a loss of 1,500 attendees. These are also substantial increases over the amounts reported four years ago.

Overall, most types of live broadcast CME activities and self-study CME activities are predominantly supported by commercial funds, with video broadcasts and video self-study receiving less support than other formats. Over the past four years commercial support has increased for all formats except telephone conferences.

Support is most often provided as a general grant to a course, for speaker's expenses, and for food and refreshments for course participants. Across several years, the trend is to more frequently provide a general grant to a course and to less frequently provide grants for specific purposes.

While virtually all medical schools accept financial support from commercial companies, some policies regarding the support vary appreciably between medical schools. About half of the medical schools have policies that: courses involving communication companies may be sponsored, all funds pass through the CME unit, university honoraria guidelines take precedence over company guidelines, and courses must have a token fee. Changes over the past four years tend toward a loosening of restrictions at some schools.

When schools charge a credit recording fee for commercially funded self-study activities, the typical fee is $20. The majority of schools find that commercial companies are "often" or "usually" timely in signing letters of agreement, timely in paying funds, and have processes making it easy for the CME unit to compose letters requesting funds from the company.

About half of medical schools held commercially funded "satellite" meetings in conjunction with meetings of national specialty societies. The "satellite" meetings were typically initiated and managed by communication companies, involved "a little" problem with oversight and management, and did not reduce funding for regional CME activities.

Communication companies. Three-quarters of the medical schools currently work with communication companies. Medical schools have a wide variation of experiences in with working with these companies, with typically "a little" problem with short time constraints, with the company following approval processes, with budget control, and with faculty contacts. Schools who are working with communication companies vary appreciably on whether they like to work with this type of company.

Most medical schools will sponsor an activity with a communication company if a member of the school's faculty is the activity director or on the presenting faculty and will not sponsor for an activity with no faculty involvement. Schools differ most on whether a faculty member reviewing an activity is sufficient content to sponsor an activity.

Paying faculty honoraria. Most medical schools agree that payment of faculty honoraria could be delegated to a joint sponsor and agree that payment should not be delegated to a speaker's bureau funded by a commercial company or to a commercial company. Medical schools disagree on the appropriateness of delegating faculty payment to a communication company, with the largest group (41%) strongly disagreeing.

Faculty development and CME. Important CME topics for faculty development include: making effective CME presentations, ethical behavior and standards regarding commercial support, CME activity planning, and CME administration. Individual consultation and written materials are available on all four topics at a substantial majority of medical schools. Scheduled group instruction is available at one-third to one half of the schools, depending on the topic.

Administering regularly scheduled conferences. The majority of schools review documentation for regularly

scheduled conferences (e.g., grand rounds) annually, while one-third review documentation much more frequently. Half of the schools require little to no detail regarding topics and speakers for individual sessions and half require detail for most or all of the sessions. Typically the content unit obtains disclosure information from faculty and arranges payment of honoraria for faculty. While schools assign the responsibilities differently, the content unit is more likely to prepare evaluation reports about the CME activity and the CME unit is more likely to maintain records of CME attendance.

ACCME System 98. About three-quarters of the respondents feel that they understand System 98 fairly to very well. A quarter of the respondents feel that it is too early to tell the effects of System 98. The other three-quarters of respondents feel that System 98 will involve either no change or a slight increase in administrative workload and no change on the quality of CME activities.

Medical schools and ACCME. About half of the respondents feel they do not know enough about the activities of representatives of "parent" organizations on the ACCME Council to know how well SACME and its interests are represented on the Council. When only the responses expressing an opinion are considered, the AAMC is viewed as representing SACME's interests "somewhat" and other parent organizations are viewed as representing SACME's interests "a little" or less. When asked if SACME and the Alliance for CME should have a directly appointed representative on the ACCME Council, responses were fairly widely distributed with the average of "agreeing somewhat."

When asked if the ACCME represents the best interests of medical schools, the fairly widely dispersed responses were slightly below neutral. Respondents disagreed with disbanding ACCME. The majority agreed that a new approach should be developed for the accreditation of medical schools' CME programs.

AAMC and the educational continuum. The majority of respondents (SACME voting members for their medical schools) are members of the CME section of the Group on Educational Affairs. A majority have some involvement in undergraduate medical education and a majority have some involvement in graduate medical education. Most agreed that the education of practicing physicians and that the office of CME are both integral parts of the educational mission of their medical schools. Most agree strongly that lifelong learning skills should be taught at all levels of medical education.

New SACME membership category. The majority of respondents agree that a membership category in SACME should be created for individuals interested in academic CME who do not otherwise qualify for membership.

Suggestions for the Next Survey

The Survey Subcommittee extends our appreciation to the CME directors and personnel who completed and returned this year's survey. Their willingness to provide information makes this report possible.

We invite members to submit suggestions to be included in the next survey. The work that goes into developing the survey, responding to it, and assembling the results is worthwhile only if the information is useful to the membership. We welcome your suggestions.

APPENDIX

Definitions Used for Audiences, Programs, and Locations

Program information. This section requests an annual summary of the programs you have offered for the past year. The terminology is explained below to clarify the question (and your responses). (A page of definitions may appear to be overkill. However, with the diversity among CME units the possibilities for confusion are enormous - - a lot more than you are thinking right now. You have to be on the receiving end of the completed surveys to begin to appreciate the variety -- and creativity -- our unguided energies can produce.)

Target audience. Physician oriented programs -- programs planned with physicians as an important portion of the audience, i.e., at least 25% of the expected audience and typically the majority of the audience.

External participants -- individuals attending your CME programs who are not closely associated with your institution; they typically do not have an appointment with the medical college/school, usually do not attend "internal" meetings such as department meetings, and usually are expected to pay registration fees for your CME programs. (A few schools have decided for local reasons to extend "courtesy" appointments to a large number of "community" physicians and even offer them CME at no charge. However, if they are not functionally part of the medical school/college, they should be classified as "external.")

Internal participants -- individuals attending your CME programs who are employed by your institution; they typically have an appointment with the medical college/school, they are invited to and usually attend "internal" meetings such as department meetings, and usually do not pay registration fees for your CME programs. (A few schools charge everyone a registration fee. If individuals are functionally part of the medical college/school, they should be classified as "internal.")

Types of educational programs. Live, in-person courses, conferences, and seminars -- the usual multiple hour and often multiple day programming for CME. Individual promotional efforts are usually associated with each of these meetings.

Presentations at county medical societies and local hospitals -- usually of limited length, routinely scheduled, and involving little if any promotional activity and a limited and defined set of individuals that are invited to attend.

Telephone and television conferences -- media transmission of events occurring elsewhere or previously.

Individual tutorials and traineeships -- participant usually comes to designated training location.

Self-study courses, either written, audio, video or computer based (from disk or via Internet) -- participant does independently, usually at home.

Internal meetings -- grand rounds, medical conferences, and other meetings primarily for members of the faculty and staff of the medical college/school.

Locations. Primary site -- the usual location for your programs. For most medical colleges/schools, this location is at or near the medical college/school.

Pleasure locations -- resorts and cities that are often visited by tourists and vacationers.

THANK YOU!

The following medical schools completed and returned the 2000 SACME questionnaire. The medical schools followed by an asterisk (*) returned it by February 28, 2000, a noteworthy accomplishment. The Survey Subcommittee extends a special thanks to the institutions below on behalf of the membership.

ALABAMA
University of Alabama-Birmingham

CALIFORNIA
Stanford University School of Medicine*
University of California at Los Angeles
University of California at San Diego*
University of California at San Francisco

COLORADO
University of Colorado School of Medicine

FLORIDA
University of Miami School of Medicine*

GEORGIA
Mercer University School of Medicine*

ILLINOIS
Northwestern University Medical School*
University of Chicago – Pritzker School of Medicine*
University of Illinois at Chicago
Southern Illinois University School of Medicine

INDIANA
Indiana University School of Medicine

IOWA
University of Iowa College of Medicine*

KANSAS
University of Kansas School of Medicine at Wichita

KENTUCKY
University of Kentucky College of Medicine
University of Louisville School of Medicine*

LOUISIANA
Louisiana State University – Shreveport*
Tulane University Medical Center*

MARYLAND
Uniformed Services University of Health Sciences

MASSACHUSETTS
Harvard University Medical School*
Tufts University School of Medicine*

MICHIGAN
The University of Michigan Medical School
Wayne State University School of Medicine

MINNESOTA
Mayo Foundation

NEBRASKA
Creighton University School of Medicine*

NEVADA
University of Nevada School of Medicine

NEW HAMPSHIRE
Dartmouth-Hitchcock Medical Center

NEW JERSEY
University of Medicine and Dentistry of New Jersey

NEW MEXICO
University of New Mexico School of Medicine*

NEW YORK
Albany Medical College*
University of Buffalo*
University of Rochester*
SUNY at Stonybrook Medical School
New York Medical College

NORTH CAROLINA
Wake Forest University*
Duke University Medical Center
East Carolina University School of Medicine
University of North Carolina at Chapel Hill

OHIO
Northeastern Ohio Universities College of Medicine*
Ohio State University College of Medicine
University of Cincinnati College of Medicine*

OKLAHOMA
University of Oklahoma College of Medicine*

PENNSYLVANIA
Jefferson Medical College
University of Pittsburgh School of Medicine*
Pennsylvania State University College of Medicine*

SOUTH CAROLINA
Medical University of South Carolina

SOUTH DAKOTA
University of South Dakota

TENNESSEE
East Tennessee State University

TEXAS
Texas A & M University Health Science Center*
Texas Tech University Health Sciences Center
University of Texas Southwestern Medical Center
University of Texas – MD Anderson Cancer Center

VIRGINIA
East Virginia Medical School
Medical College of Virginia*
University of Virginia School of Medicine*

WASHINGTON
University of Washington School of Medicine

WEST VIRGINIA
West Virginia University School of Medicine

WISCONSIN
University of Wisconsin Medical School

CANADA
Dalhousie University Faculty of Medicine
University of Calgary*
University of Toronto Faculty of Medicine*
University of Ottawa*