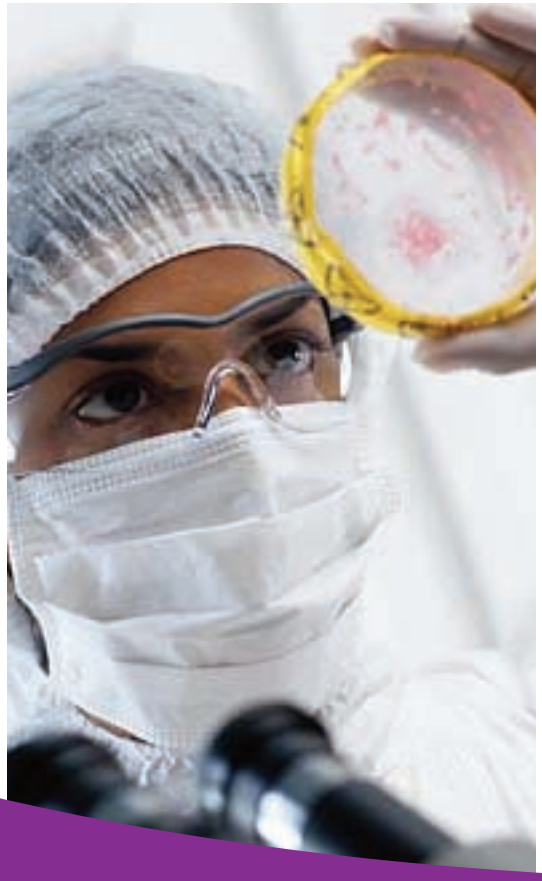
The Society for Academic Continuing Medical Education

AAMC
Tomorrow's Doctors, Tomorrow's Cures®

Academic CME in North America: The 2008 AAMC/SACME Harrison Survey



Association of
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Executive Summary

A survey of academic CME, developed as a collaborative partnership between the Society for Academic CME (SACME) and the AAMC, was distributed online in the fall of 2008 to 137 medical schools in the United States and Canada. With a response rate of over 80 percent, the survey provides a reasonable platform on which to assess the activities and potential of both countries' academic continuing education programs and activities. While sizable efforts in these schools continue to generate hundreds of courses and conferences, and accredit regularly scheduled conferences or rounds, other activities demonstrate an increased, scholarly attention to the principles of effective continuing education and adult learning, and/or to innovative programming in online, outreach, or other formats. Other findings include: an increase compared to earlier SACME surveys in the percentage of physician-leaders in CME; a continued reliance on commercial support (especially in U.S. schools) and a commensurate lack of institutional support for CME; and notable examples of increased linkages to internal programs and departments such as performance improvement, residency or allied health education, faculty development, and other entities. In total, the survey presents a picture of sizable traditional educational activity, in addition to important efforts to link more fully with the academic medical center.

Section 1: Introduction

Background

This is the first annual survey jointly sponsored by the Society for Academic CME (SACME) and the Association of American Medical Colleges (AAMC), in collaboration with the Association of Faculties of Medicine of Canada (AFMC). The survey was derived from previous surveys of academic CME providers conducted over the last two decades by SACME. Its name, "The Harrison Survey," recognizes the dedication and commitment of R. Van Harrison, Ph.D., of the University of Michigan, who led the Society's CME biannual survey efforts during this period.

This survey included questions about the organization of the CME unit, its relationship to the larger organization in which it resides, the "product" of the CME program (courses and other activities and interventions), its funding base, research and innovation, and other items related to the operation of the CME unit.

Survey Development, Testing, Response Rate

The questionnaire was developed over a six-month period in early 2007, based on the original SACME surveys. It was pilot-tested for both technical and questionnaire format in mid-2008. Subsequently, it was distributed online using the Web application *Vovici* on October 3, 2008, for a period of six weeks to all CME directors in 137 medical schools in the United States and Canada. Three e-mail reminders were sent to those who had not yet completed the survey. All financial and other reporting data were based on the last Accreditation on Council for Continuing Medical Education (ACCME) fiscal year (2007).

Of the 137 medical schools that received the questionnaire, 114 (13 from Canada and 101 from the United States) responded, giving an overall 83 percent response rate (Table 1). The survey required that the CME program be accredited by the ACCME. All but four respondent CME units fulfill that requirement, eliciting a 96 percent accredited status among responders; no answers were recorded from these four institutions. Those four nonaccredited programs were from the U.S. medical school pool and were excluded from completing the survey. Among the 97 remaining institutions, 62 are public and 35 are private.

Table 1: Response Rate by Canadian vs US and Accredited/Nonaccredited Status

Institution	U.S. schools	Canadian schools	Accreditation status	
			Yes	No
Number of respondents	97	13	110	4
Number of nonrespondents	23	4		27
Response rate	81%	76%	96%	
Overall response rate	83%			

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Survey Reporting: Comparison with Other Survey Years

While there was a high overall response rate to this survey, not all questions were answered, or answered completely. This report indicates the numbers of CME units reporting on each question, the means and median figures where appropriate, and the percentages (in round figures), or numbers of schools for those CME units in each category. For most questions, the overall response rate is described, and in some instances, such as funding questions or research productivity, other parameters were considered important (for example, U.S./Canadian descriptors). Since the Canadian/U.S. currency exchange rate at the time of this survey completion was virtually equivalent, these dollar values are considered as comparable. Finally, in some areas, the current survey data are compared with previous SACME surveys to assess longitudinal trends. These comparisons may be limited by a possibly different population of respondent schools and a smaller response rate on earlier surveys.

Section 2: The Organization and Structure of the CME Unit

Educational Background and Salary of the Director

The survey assessed the educational background of the "director" of CME—in most cases, the individual who completed the survey. A wide variety of educational levels is represented in the response. The majority (34 percent) hold master's degrees, while individuals holding an M.D. degree account for roughly 30 percent (a combination of 27 percent of M.D.s and 2 percent of M.D./Ph.D. holders). CME "directors" with Ph.D. degrees account for almost 15 percent of the total, a slight increase from the 13 percent noted in the previous SACME survey. See Table 2.

When comparing these data to the previous SACME survey (2006), we note an increase in the number of MDs reported as directors of CME, from 17 percent to 30 percent. This comparison, striking as it is, needs to be judged with caution since the respondent populations may be dissimilar, and since a variety of organizational and reporting structures (some of which are explored below) exist in CME units.

Table 2: Education of Person Completing the Survey

Item	Number reporting	%
Bachelor's degree	17	18
Master's degree	32	34
MD	28	29
PhD	14	15
Have no degree	4	4
Total reporting	95	100

Overall 63 units (6 from Canada and 57 from the United States) responded to the question about compensation (excluding benefits) of the director of CME (Table 3). In Canada, all CME directors have either M.D. or Ph.D. degrees.

Table 3: Salary of the Director

Item		Canada	United States
Number reporting		6	57
Mean		$ 80,000	$ 89,931
Maximum		140,000	250,000
Percentiles	25	50,000	64,500
	50	65,000	76,923
	75	117,500	110,525

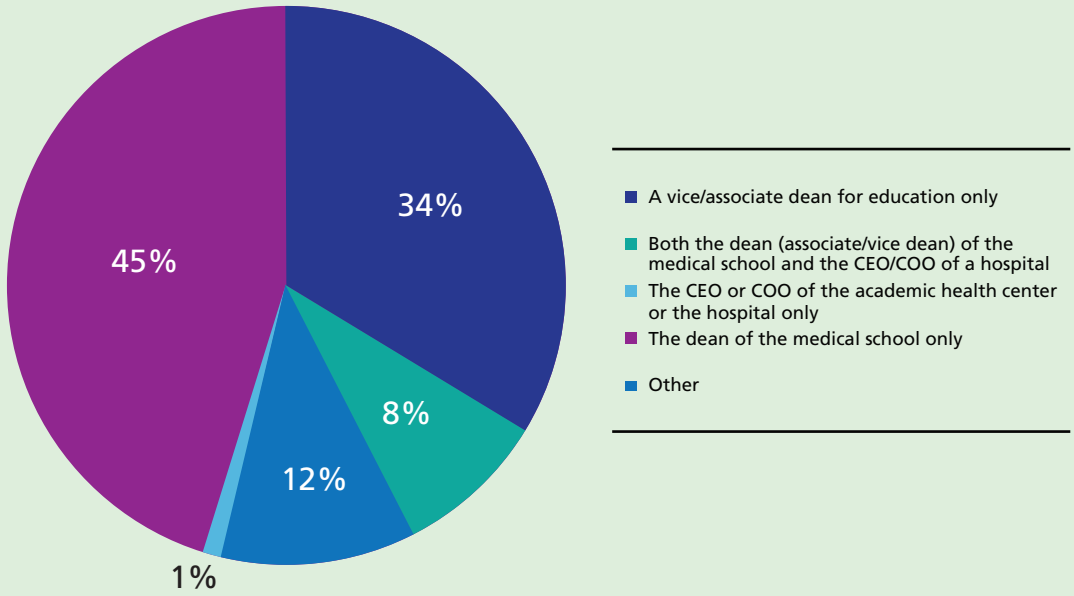
The CME Unit's Title

Various names are given to units responsible for continuing education activities, but in most instances, they are called the "Office of CME" (roughly 50 percent of respondents). Other less common names include the Office of Continuing Professional Development (CPD), a combination of both CME and CPD (e.g., the Office of CME & PD), the Office of Faculty Affairs and Professional Development, and other variations.

Reporting Structure

While there was some variation in the reporting structures of these units, roughly half (45 percent) report to the dean of the medical school only; a third (34 percent) to a vice/associate dean for education. Much smaller percentages of units report to both the dean of the medical school and the CEO/COO of a hospital (8 percent). Other reporting lines include deans or other leaders for outreach, external affairs, faculty affairs, medical education, and alumni affairs, and the CEO or COO of the academic medical center. One respondent reports to a senior associate dean for finance; others report to vice chancellors, representing a university-wide structure. See Figure 1.

Figure 1: Reporting Structure



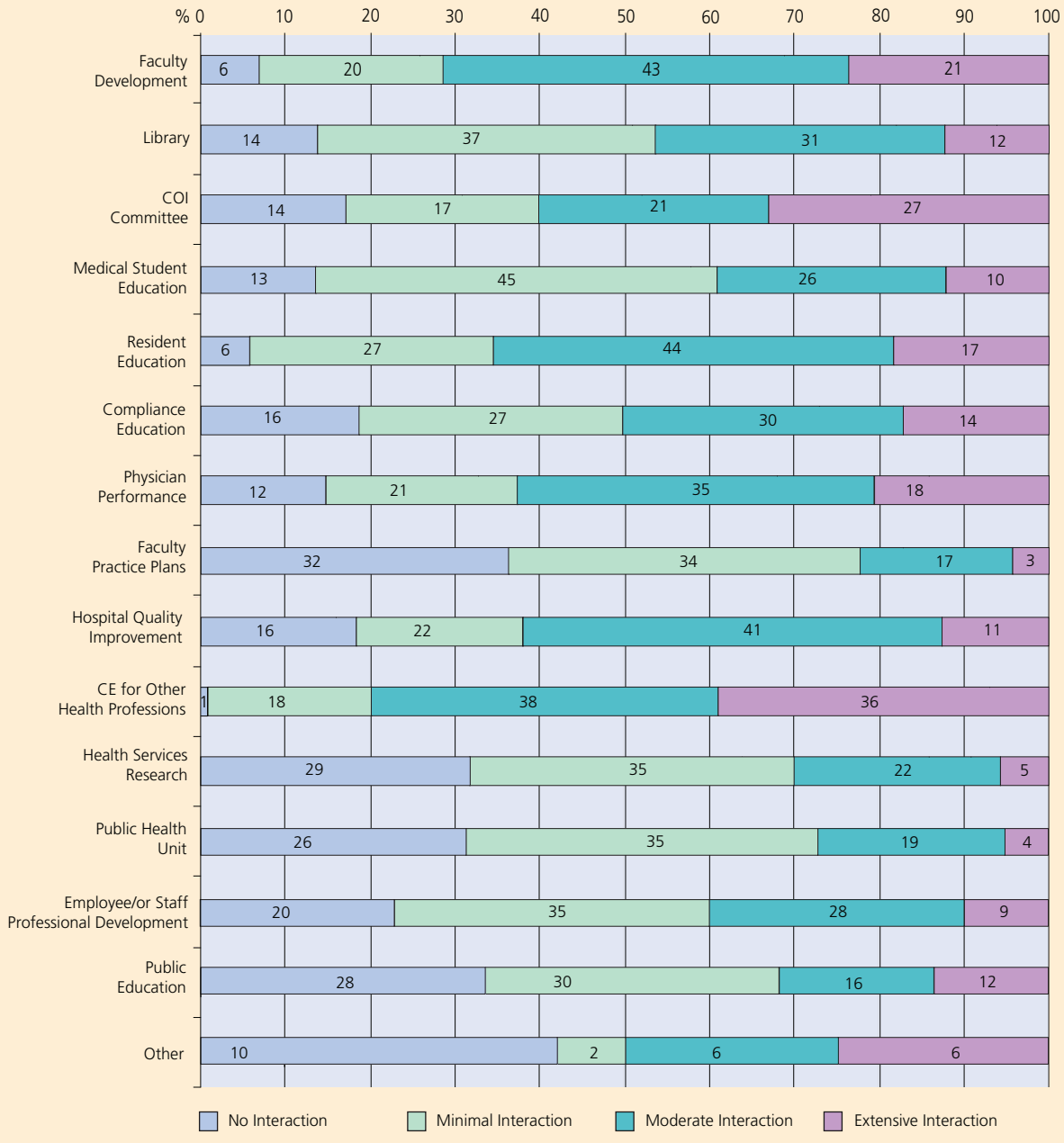
Section 3: Internal and External Relationships of the CME Units

Internal Relationships

Respondents were provided a list of programs, departments, and units, both internal and external to the academic medical center, which might exist in their respective settings. They were asked to select the status that best described the relationship between the CME office and each of those programs, on a scale ranging from no interaction, to minimal, moderate, or extensive interaction. Minimal interaction was described as irregular or occasional activity linked to the program or unit, whereas extensive interaction was characterized as ongoing planning or developmental activity, conjoint programming, shared goals and strategic directions, or shared resources.

The internal relationships include: faculty development programs, library services, conflict of interest committees, medical student or resident educational programs, compliance education, physician performance or quality improvement units, faculty practice plans, continuing education for other health professions, health services research, public health, employee or staff professional development, and public education (for example, mini med school). See Figure 2.

Figure 2: Internal Relationships of the CME Unit with Internal Academic Medical Center Programs (number of units reporting indicated in bars)



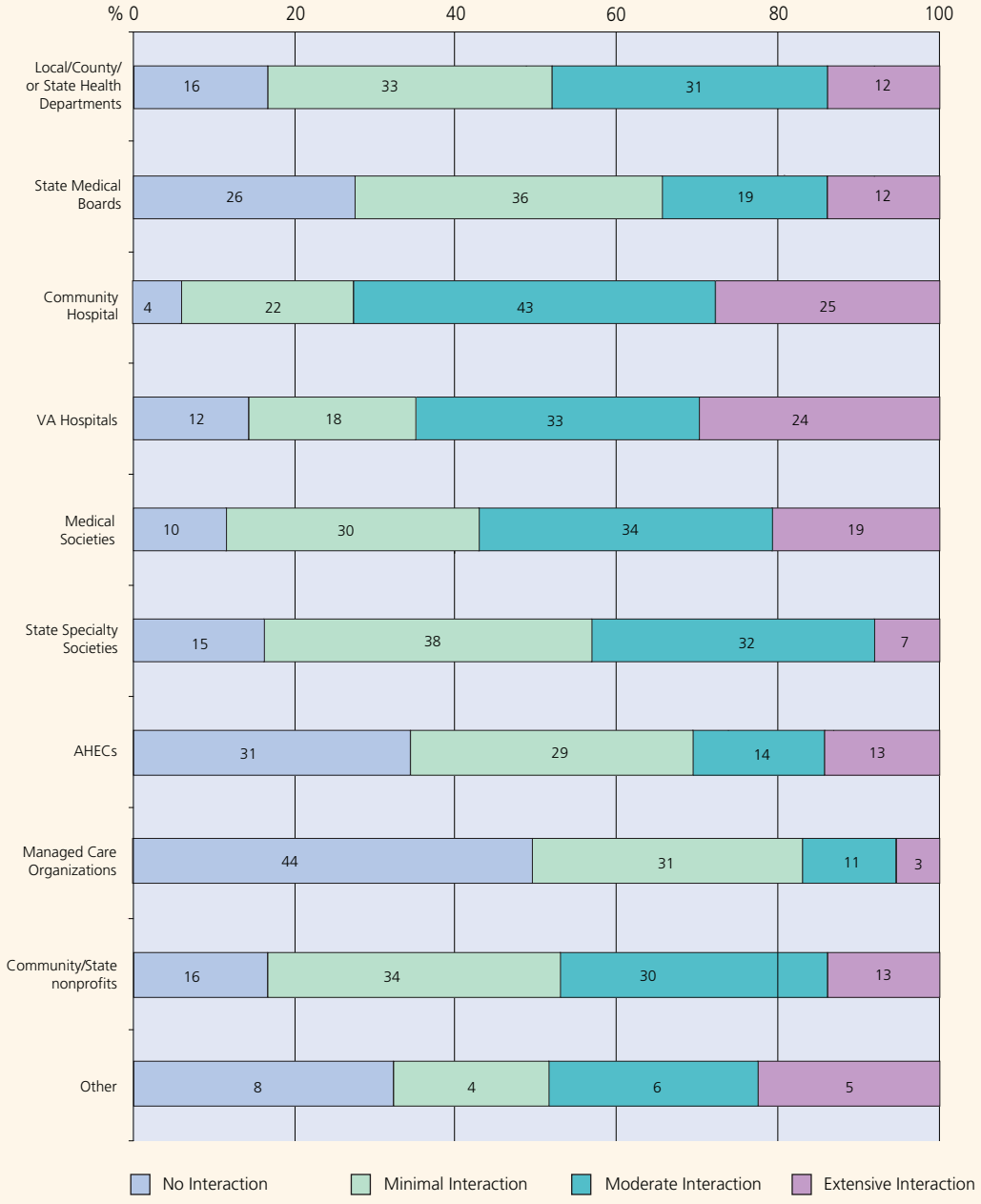
While Figure 2 reveals the details of internal integration of the CME unit, several findings are of interest when responses for "extensive" and "moderate" interaction are collapsed. A little over three-quarters (78 percent) of the responding institutions indicate moderate or extensive interaction with continuing education programs for other health professions; while over two thirds (69 percent) express a moderate or extensive interaction with faculty development programs. Less integration is noted in four areas; resident education (64 percent), physician performance (56 percent), hospital quality improvement (55 percent), and COI committees (52 percent). Further, several interactions are much less frequent or nonexistent among reporting units. For example, roughly one-third of schools report no interaction with faculty practice plans (34 percent), health services research (31 percent), public health units (31 percent), or public education programs (31 percent). Smaller but significant gaps also exist in interaction with conflict of interest committees.

These interactions—or their absence—may be informed by understanding the overall organizational structure of the academic medical center, including its medical school/hospital ownership, configuration, and integration.

External Relationships

The survey also asked about relationships between the CME unit and organizations external to the medical school. A list of community or state organizations was provided, including local/county/state health departments, state medical boards, community hospitals, VA hospital(s), local and state medical and specialty societies, Area Health Education Centers (AHECs), managed care providers or third-party payers, and community or state nonprofit organizations. Among these, CME units indicate most interaction with community hospitals (72 percent) or VA hospitals (60 percent). A relatively smaller but important percentage report interaction with medical societies (56 percent), community or state nonprofits (45 percent), local/county/state health departments (45 percent), and state specialty societies (41 percent). Much less interaction is noted between CME units and state medical boards and area health care centers (AHECs) (respectively 33 percent and 28 percent). Also of significance, roughly two-thirds of units report no or minimal interaction with AHECs (64 percent) or state medical boards (65 percent), while more than half (52 percent) indicate similarly low levels of interaction with local, state or regional health units. Finally, in areas where little or no interactivity is indicated, nearly half (46 percent) reported no interaction with managed care providers or third-party payers, and a further 33 percent have minimal interaction (Figure 3).

Figure 3: CME Unit Relationships with Organizations External to the Academic Medical Center (number of units reporting indicated in the brackets)



Section 4: The "Product" of CME Units

Formal, Planned Traditional Educational Activities of CME Units

Conferences and courses

"Traditional educational activities" represent common forms of CME as defined in previous SACME surveys. These activities include planned courses, conferences, refresher programs, and similar educational events held in calendar year 2007 (identical to the ACCME fiscal year), the total number credits hours offered in those programs, and the number of physician and nonphysician participants. Eighty-seven CME units responded to questions about these activities.

While there is a wide range of courses developed (from 1 to over 1,300) on average, CME units produce 147 courses on a yearly basis. The median course offering was 101. In providing this wide-ranging service, the average CME unit provides approximately 3,206 credit hours and attracts an attendance of 9,193 physicians and 4,656 nonphysicians.

Table 4: Traditional CME Activities
Numbers of planned courses, conferences and refresher programs; credits and participants (87 CME units reporting)

Item		Total number of courses held in the last year	Total number of credit hours offered in these courses	Number of physician participants	Number of nonphysician participants
Mean		147	3,206	9,193	4,656
Percentiles	25	57	480	1,854	1,062
	50	101	1,062	4,600	2,633
	75	159	2,188	12,692	6,602

Enhancing traditional CME activities

The CME research literature indicates that course impact may be enhanced by the use of "practice enablers" (patient education materials, flow-sheets, algorithms, and other materials to be used in clinical care distributed at or after the course), or follow-up methods post-course (e.g., by e-mail, mailings, conference calls, etc.). Examples and definitions were provided in an attempt to be as specific as possible in these categories, using both SACME and ACCME definitions where possible. The responses reflected a slow uptake of these methods: only 13 units (15 percent) reported that they regularly use "practice enablers," whereas 40 units (46 percent) use them occasionally. Similar proportions (15 percent) reported using post-course methods regularly, while 39 units (45 percent) use them occasionally.

Respondents were also asked if they used simulations, and/or quality improvement or performance improvement data sources as needs assessment or outcomes assessment methods. Less than 5 percent of CME units indicate that they use simulations (standardized patients, audio, video resources, actual simulators, etc.) on a regular basis; about 44 units (51 percent) use them occasionally. Finally, quality or performance improvement data sources are used as needs assessment regularly in 23 institutions (26 percent), while 52 units (59 percent) use them only occasionally. Only seven units (8 percent) use quality or performance data sources in a regular fashion to evaluate their impact, whereas 40 units (46 percent) use them occasionally. See Figure 4.

Figure 4: The Use of Evidence-based Course and Program Aids
(number of units reporting indicated in bars)

Regularly scheduled conferences, series, or rounds (RSS)

CME units typically provide credit for regularly scheduled conferences, series or rounds (RSS). In 2007, 82 units report providing an average of 83 such RSS activities, with a median of 48, averaging 2,274 credit hours offered in those series. These activities attract more than 13,000 physician and 4,500 nonphysician participants. In total, respondents indicate that they provide 6,768 regularly scheduled conferences, series or rounds last year, totaling 184,188 credit hours, garnering 1,079,093 physician visits and 355,940 nonphysician visits. See Table 5.

Visiting speakers' programs; individual traineeships

CME units also offer visiting speaker programs, and presentations at state medical societies, area hospitals, and in other venues. The number of units offering these activities is relatively small with only 27 units indicating that they offer such activities. In total, 1,198 activities were offered, totaling 4,235 credits hours and attracting 40,267 physician and 9,980 nonphysician participants. Table 5 also lists data on traineeship programs.

Asynchronous audio, video and online courses

Participants were asked to provide the numbers of asynchronous audio, video, and online courses offered by their CME units. Seventy-seven CME units provide an average of 170 video, audio, or asynchronous courses, for a total of over 13,000 such activities, attracting over 500,000 physician visits and over 200,000 fewer nonphysician visits. See Table 5.

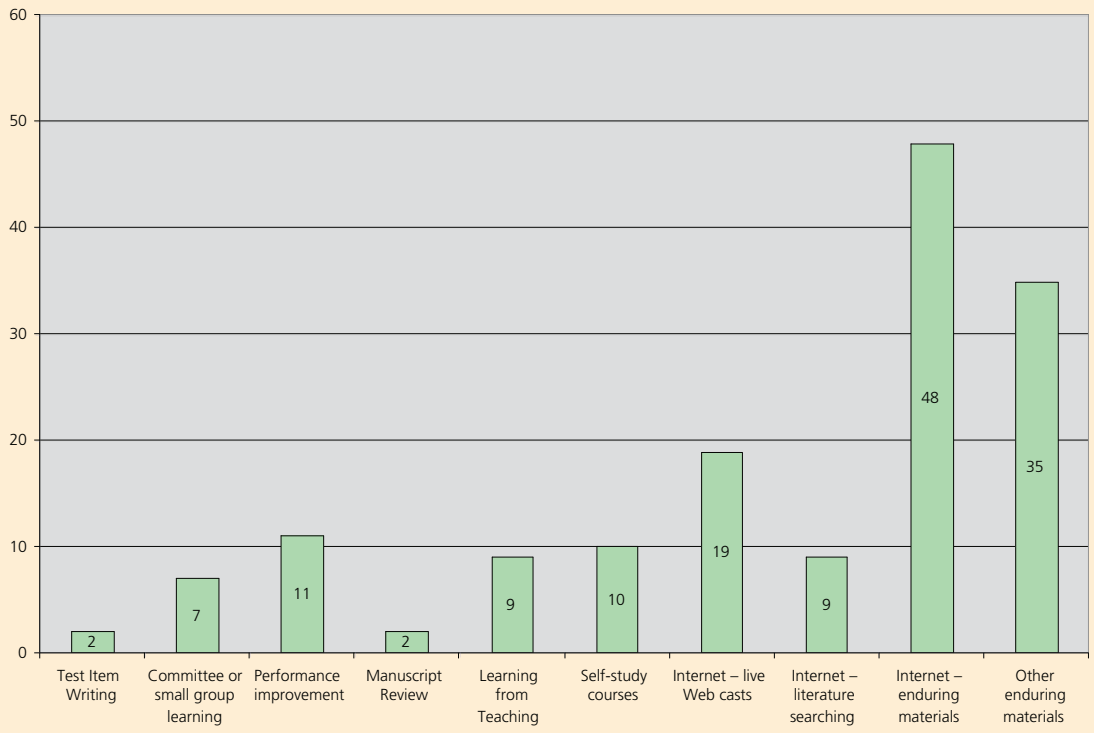
Table 5: Data related to regularly scheduled conferences, series, or rounds; visiting speakers' programs, traineeships and audio/video/online courses (For the number of physician or nonphysician participants, each participant is recorded for each round attended)

Item	No. of units reporting	Total no. offered	Mean	Median	Total credit hours	Total participants physician	Total non physician participants
RSS	82	6,768	83	48	184,188	1,079,093	355,940
Visiting Speakers	27	1,198	44	19	4,235	40,267	9,980
Traineeships	31	250	8	3	7,344	4,370	75
Audio, video, online courses	77	13,062	170	6	19,700 (74)	510,223 (74)	276,976 (73)

Alternative Learning Activities for CME Credit

The survey inquired about other activities included in ACCME-surveys such as test item writing, committee or small group learning, performance improvement, manuscript review, and others, specifically designated as eligible for CME credit by the AMA. CME units were asked to indicate if they provided those activities; only a few do so. For example, only one school indicates that it provides credit for manuscript review, and none offers test item writing for CME credit. In contrast, Internet-live Web casts are offered at 15 schools. Further, an average of 1,458 physicians participated in self-study courses, while 418 nonphysicians participated in the same activity. See Figure 5.

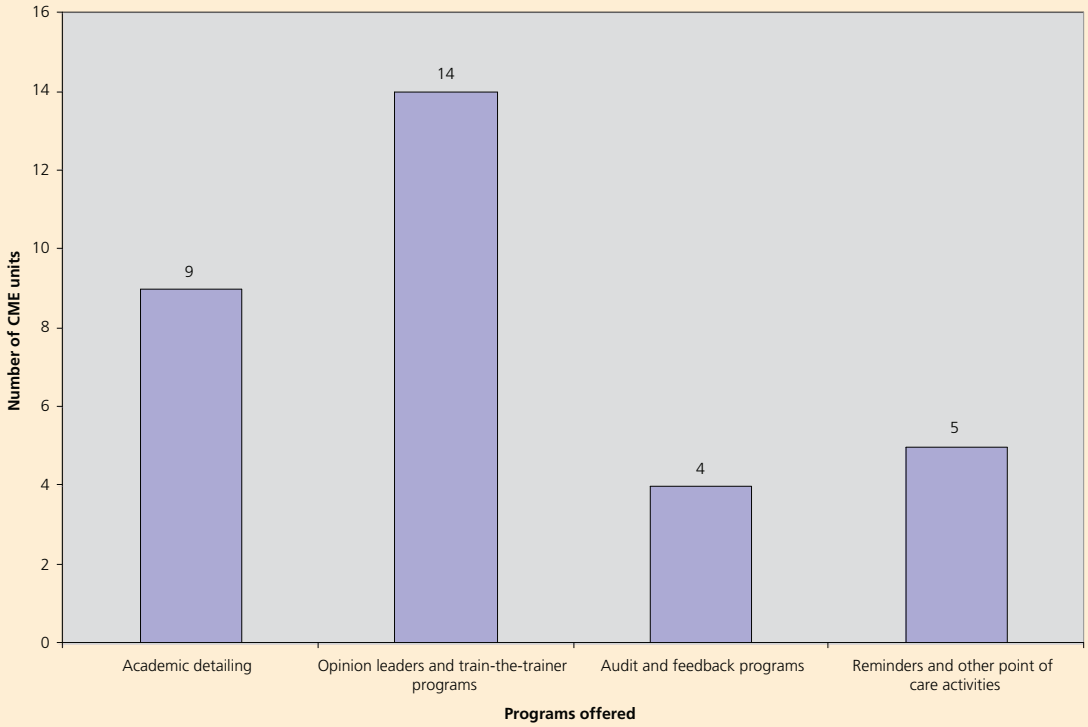
Figure 5: Alternative ACCME identified Learning Activities



Alternative Educational Interventions

The broader CME literature, derived from health services research and related fields, describes a fairly broad range of more proactive educational interventions such as academic detailing, opinion leader and train-the-trainer programs, audit and feedback, reminders, and other point-of-care activities. They are considered by many to offer more effective and proactive alternatives to didactic forms of CME. These appear to be infrequently used by academic CME units, although a small number (9 units) do provide outreach activities in the form of academic detailing. These schools provide a mean of 24 credit hours, and reach 992 physician and 138 nonphysician participants. See Figure 6.

Figure 6: Alternative Educational Interventions



The Target Audience of Academic CME

The survey also asked CME units to estimate the percentage of their activity that targeted an internal versus an external audience, and primary care, specialist or interprofessional audiences. On average, over one-third (39 percent) target an internal audience, while less than one-quarter each target programming to external primary care physicians (24 percent) and an external physician specialist audience (19 percent); roughly one-quarte (24 percent) attract an interprofessional audience (doctors, nurses, social workers and others). Very few (< 4 percent) reach out to the public or patients.

Section 5: The Funding of Academic CME

The survey asked several questions related to the funding structures and policies, income and expenses of the CME unit budget.

Budget Models

When asked about models of financing the CME unit, over half of the respondents (54 percent) report a blended model in which the CME unit has some budget components separate from that of the institution, in addition to some institutional support (e.g., salaries, computer services) indistinguishable from that of the parent institution itself. Thirty-four units (43 percent of the respondents) report that the CME unit budget is entirely separate from other parts of the organization's budget. Finally, only three medical schools (<4 percent) report that most (or all) of the CME budget is embedded in the full budget of another unit or program (e.g., educational affairs) of the organization or institution, and is not easily distinguished.

Academic CME Revenues and Expenses

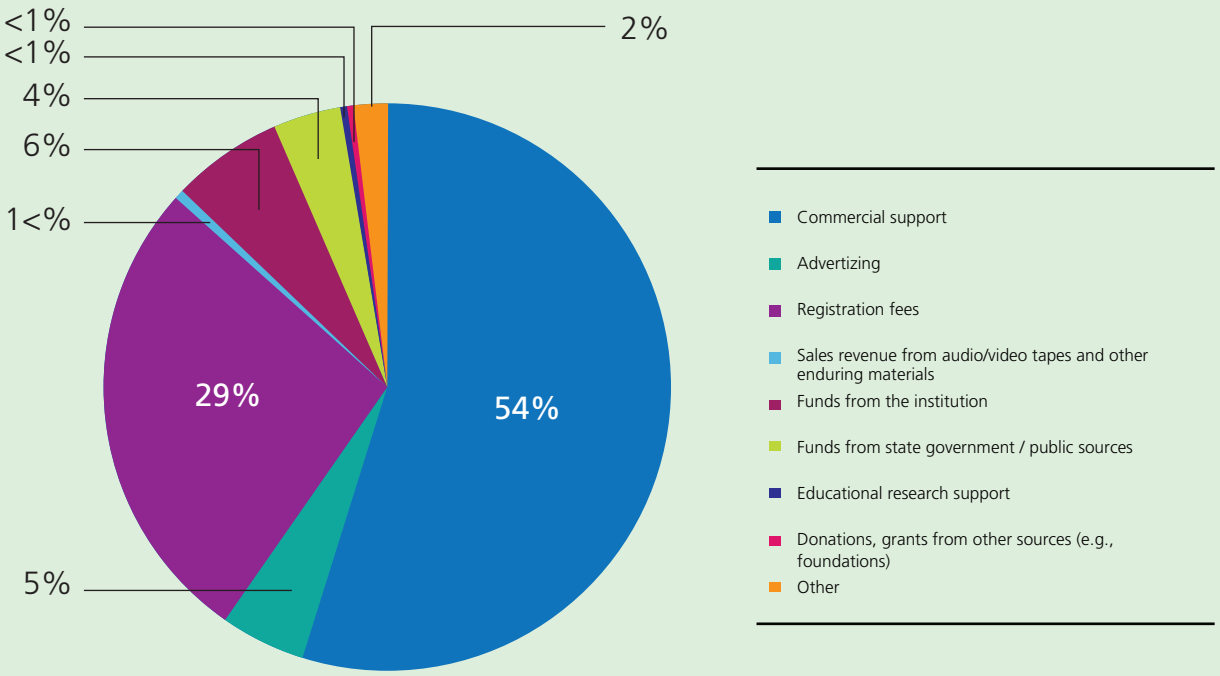
For calendar year 2007, CME units were asked how much revenue they generated from a variety of previously selected sources. In total, the 83 CME units report almost $270 million in annual revenue, of which they spend slightly under $250 million ($246,362,675). An analysis of these total figures describes much of the current picture of academic CME's funding base. See Table 6.

Nearly $140 million ($144,384,926) derives from commercial support, roughly twice that of the second major funding source, registration fees ($76,916,261). In contrast, only $549,933 came from educational research support (See Table 6). Other sources of income are also noted, including institutional funds, advertising and exhibits, funds from the state government, and from income other sources. Figure 7 provides a graphic display of revenue streams.

Table 6: Revenue streams and overall expenses for academic CME units (number of reporting in brackets)

Item	Maximum	Mean	Median	Total	Total %
Commercial Support (76)	$31,594,223	$1,899,802	$589,805	$144,384,926	54%
Advertising (72)	2,758,248	173,430	87,440	12,486,960	5%
Registration fees (72)	9,552,390	1,068,281	616,155	76,916,261	29%
Sales revenue from audio/video tapes and other enduring materials (22)	448,470	53,165	9,915	1,169,623	<1%
Funds from the institution (48)	2,758,266	340,166	207,566	16,327,957	6%
Funds from state government/ public sources (18)	5,000,000	537,787	133,249	9,680,165	4%
Educational research support (4)	400,000	137,483	68,967	549,933	<1%
Donations, grants from other sources (e.g., foundations) (20)	100,000	35,056	22,500	701,127	<1%
Other (29)	700,685	157,715	81,856	4,573,730	2%
Total revenue				**$266,790,691**	
Total expenses				**$246,362,675**	

Figure 7: Revenue for Academic CME units



Funding models differ significantly between U.S. and Canadian schools. In general, much less commercial support is noted in Canadian schools versus their U.S. counterparts (14 percent vs. 56 percent). Similarly, institutional support varies commensurately; Canadian schools CME units receive over 17 percent of their support from institutions, three times more than their U.S. counterparts. One area is roughly similar between the two countries; registration fees generate roughly one-third (30 percent) of the income in both the United States and Canada. Compare figures 8a and 8b.

Figure 8b: Revenue for Academic CME Units in Canada

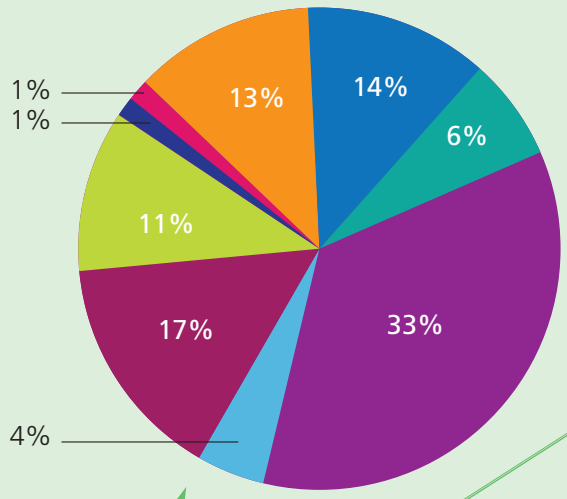
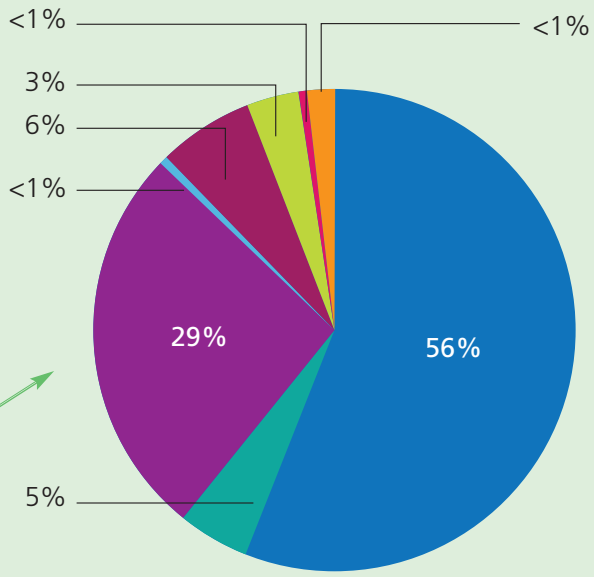
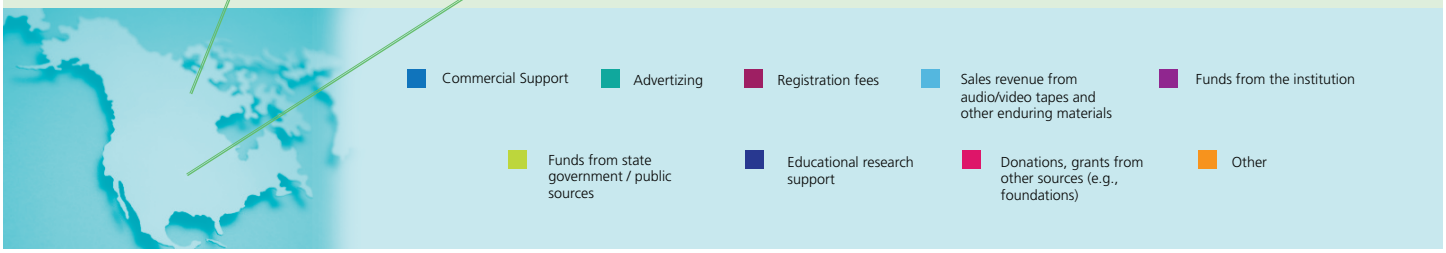


Figure 8a: Revenue for Academic CME Units in the United States





The Issue of Commercial Support

Given the dependence of these units on industry support, at least among U.S. schools—and the wide attention such funding receives in the press and elsewhere—the survey asked specific questions about the degree and role such support plays in the academic CME enterprise. An analysis of the data from 82 CME units suggests the following picture. The "average" academic CME unit conducts 145 yearly activities that receive financial support from commercial sources. Of these 145 activities, over one-third (51) are solely supported by commercial support, and almost all (121) would not have been offered had commercial support not been available. See Table 6, which reports total figures for 76 CME units, and Table 7.

Table 7: Extent and Impact of Commercial Support (82 units reporting)

Item		Number of activities receiving financial support from commercial sources	Number of activities solely supported by commercial funds	Number of activities that would not have been offered without commercial support
Mean		145	50	121
Total		11,912	4,104	9,917
Percentiles	25	17	0	5
	50	46	9	20
	75	78	30	50

CME Revenue Distribution

The survey gathered information on how financial deficits or surpluses are allocated between the CME units and collaborating departments. Here, 96 units report the following distribution pattern: a half, 48 units (50 percent) indicate that all deficits and surpluses are the responsibility of the cosponsoring unit (e.g., clinical or academic department); 24 units (25 percent) report that all deficits and surpluses are shared between the CME unit and the cosponsoring unit by some negotiated arrangement; and 19 units (20 percent) keep all deficits and surpluses. A much smaller number of units (5 percent) indicate variations to this overall model; for example, keeping 10 percent of revenue in the CME unit, maintaining deficits as the responsibility of the cosponsor while surpluses are either shared or rolled over into another activity, and requiring deficits to be borne by the cosponsoring unit while surpluses are shared between the CME and cosponsoring unit on a 30/70 split.

Section 6: Internal and External Policies in CME

To determine the extent to which CME units have adapted or produced policies, several areas were targeted for consideration. These areas included policies related to administrative fees, registration fees, promotion and tenure related to engagement in CME, faculty honoraria, commercial conflict of interest, and other. Not surprisingly, most academic CME units have adapted or created policies related to fiscal and administrative issues, such as faculty honoraria. In contrast, most units have no established policy (or are unaware of the existence of such policies in the larger institution) for rewarding or acknowledging faculty involvement in CME as a consideration in promotion and tenure. See Table 8.

Table 8: CME Unit Policies

Policy area	Number of units reporting	Number with original policies	Number with adapted policies
Administrative fees	58	40	18
Registration fees	39	32	7
Faculty Honoraria	58	38	20
Promotion/Tenure for CME activity	11	8	3
Commercial COI	62	21	41
Other	15	10	5

Finally, the survey asked U.S. schools to what extent the new ACCME criteria required them to make changes in the operation of their CME units. Eighty percent of the 82 schools who responded reported a moderate or extensive change in their operation as the result of ACCME policy changes.

Section 7: Research and Development in Academic CME

Reflecting a unique accreditation requirement in Canada and a voluntary activity in the United States, institutions were asked if they participated in research or development activities. Of the 110 units reporting; 34 units indicate such participation—eight in Canada and 26 in the United States.

A subset of 18 schools report on the specifics of grant capture and studies undertaken in the past year. The number of studies undertaken by these CME units varies from one to 20; four units reported undertaking three studies, while one school attracted 20 grants. In total, these 18 units garnered nearly $12 million ($8.3 million in grants, studies and research activities). While four grants were relatively small (in the $20,000-50,000 range), several were much larger, ranging from $250,000 to $4 million. When asked what percentage of the research or developmental activity was done by individuals located in the CME unit, six of the 18 reporting units indicate that all of the research was done by individuals located in CME unit only; four units report that their research was undertaken by individuals located elsewhere in their institution; and a shared model is reported by the remainder. See Table 9 for further details and a breakdown of Canadian and U.S. data.

Table 9: Research and Development Activities Reported by CME Units

Institution type	Number of units reporting CME R&D	Total number of grants undertaken (number of reporting CME units in brackets)	Total dollar value of grants
Canadian	8	10 (3)	$57,146
US	26	62 (15)	$11,643,000
Totals	34	72 (18)	

Finally, the survey asked respondents to indicate their "best practices"—innovations, initiatives, programs, and other interventions that exemplify the creation of activities to enhance the effect and scope of 'CME'. While frequently not funded through peer-reviewed or other formal granting mechanisms, these initiatives do represent major efforts on the part of academic CME providers. Nearly 50 such best practices are reported, ranging from staffing issues (e.g., adding an individual to facilitate grant capture or to manage evaluation and assessment), to educational issues (e.g., addressing evidence-based medicine or hand hygiene), to new modalities in CME (e.g., performance improvement activities). By far, the largest number of innovations and best practices can be termed "integrative"—developing active, working linkages with health systems, hospitals, conflict of interest groups, and other educational programs in the institution.

Section 8: Discussion and Insights

The survey's development and history, response rate, and findings offer sizable opportunities for comment.

First, this is an important collaborative step undertaken by the AAMC and the SACME. In undertaking this effort, the AAMC acknowledges the pre-eminent role the SACME plays in the scholarship and development of CME units within the academic medical centers of the United States and Canada. For more than 30 years, the SACME has supported research, publication, and scholarship in the field, aided the professional development of its members, and secured major leadership positions within academic medicine. The SACME's role, under the leadership of Van Harrison, University of Michigan, has been recognized earlier in this report.

Second, the survey response rate of over 80 percent represents several unique features of this effort: its collaborative nature, its online and proactive reminder strategy, thoughtful external questions about the funding structures and effect of CME, and perhaps a growing awareness that CME is an integral comment of the complex workings of academic medical centers.

Third, there are many limitations to this survey and hence to its interpretation. It is possible that the population of respondents to the previous SACME surveys is different from that achieved by this survey; clearly, previous surveys were sent only to SACME members, a subset of the total academic CME community. Nevertheless, response rates from past surveys (over 60 percent) are also high, and the range of schools by size and in other characteristics appears to be similar. Nonetheless, caution needs to be taken in cross-survey comparisons. Further, survey responses were entirely self-reports. Where possible, other data sources were checked (ACCME reports, for example); in general they appeared to be similar to this survey. Finally, not all schools responded to all questions, possibly suggesting survey fatigue, or hesitation on the part of some schools to report more sensitive data such as that related to funding or the effect of ACCME policies.

Fourth, and despite these cautions, there are many areas in which comment may be made about strengths, opportunities and concerns in academic CME. Areas of notable strength are easily found in these results: an increasing diversity of CME offerings, well beyond the traditional, didactic conference or course model; a relatively small but important recognition of scholarly activity in CME; the presence of commercial support and other logistical policies; and an increased number of physician-leaders, joined by other colleagues, in CME. The survey also presents many areas of opportunity. In particular, collaborative partnerships internal and external to the academic medical center, more apparent in some areas than in others, offer the possibility of adding value to the academic medical center in quality and patient safety, other educational programs, health services research, and regional outreach. While challenging, they also offer the possibility of enhanced funding for CME. At least in the United States, a heavy reliance on commercial support carries with it the potential for activity generation unrelated to the goals of the academic medical center, and calls for reflection on this phenomenon.

Finally, several areas deserve further exploration within the current survey results, and for ensuing iterations. Within the current survey data, there is sizable room for further analysis by country, public versus private status, and organization of the academic medical center. In future surveys, more detailed questions about the state of CME funding and disposition of revenues may also shed more light on the questions of financial support to, and possibilities inherent in, fiscal issues related to CME.

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Finally, the efforts of R. Van Harrison, Ph.D., University of Michigan, to build a database on which to compare years of activity and track changes within the academic CME community are remarkable and have provided a robust platform on which to build further analyses of the place and role of CME in education, research, and service in the academic medical center. This survey and its summary are a tribute to his energy and commitment to that process, and that of the Society for Academic CME.