

OUTSTANDING PROGRAM TAKING SHAPE FOR SACME FALL MEETING 2003

The Society for Academic Continuing Medical Education (SACME) Fall 2003 meeting will be held November 7-10, 2003 in Washington, D.C. in conjunction with the 114th Annual Meeting of the Association of American Medical Colleges. The SACME meeting will be held in the Washington Hilton Hotel.

Melinda Steele, M.Ed., Chair of the Program Committee for the Fall meeting said, "We are excited to announce that we have confirmed Arnold S. Relman, M.D. of Harvard Medical School to speak at the Fall meeting regarding his recently published articles about CME, commercial support, and alternatives to funding academic CME. Articles authored by Dr. Relman have appeared in *New Republic*, *JAMA*, and other periodicals. His most recent is in the

May 14, 2003 issue of *JAMA*. "We have also invited a representative from the Washington Legal Foundation to speak and participate in a panel discussion with Dr. Relman. At this writing, we are awaiting confirmation."

Other topics on the preliminary program include competency based licensure and implications for CME, maintenance of certification, and SARS: lessons for CME. Sessions on best practices, research in continuing medical education, and hot topics will also be included.

Ms. Steele continued, "The Fall line-up looks exciting and we anticipate attracting many attendees outside of SACME just as last Fall's program did in San Francisco. Share the information with your colleagues in other areas and invite them to attend our general sessions."

Information will be updated regularly on the website (<http://www.sacme.org>) and messages will be sent to the list-serve as new items are confirmed and added to the program.

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Washington, D.C. is the location for the 2003 Fall meeting of the Society for Academic Continuing Medical Education in conjunction with the 114th Annual Meeting of the Association of American Medical Colleges. The SACME meeting will be held in the Washington Hilton Hotel. Check the website for updates and registration information: <http://www.sacme.org>



Images courtesy of the Washington, D.C. Convention and Tourism Corporation (WCTC).

FROM THE PRESIDENT

NEW VISIONS FOR CME: SACME COLLABORATION, CHALLENGES, CONTINUITY, COMMUNICATION

By Nancy Davis, Ph.D.

The Spring 2003 Society for Academic Continuing Medical Education (SACME) meeting in Santa Fe began with a session on new visions for CME. Since some are not so new anymore, this gave us an opportunity to examine how far we have come in implementing what we know to be more effective CME. It also provided a time to reflect on continuing barriers to changing not only physician behavior, but our own practices as CME professionals.

Collaboration

SACME, as an organization, is growing in numbers and strength with new memberships steadily increasing over the past year. We welcomed our 200th member at the Spring meeting. While some new members are from specialty societies as a result of expanded membership eligibility, most new members have come from medical schools. The opportunity for collaboration between medical schools and specialty societies has never been better.

The American Board of Medical Specialty Societies will require all specialty certifying boards to implement their plans for maintenance of certification (MoC) by July 2003. Of the four components of maintenance of certification, CME can play a major role in two: lifelong learning and self-assessment and performance measurement in practice. Meeting the needs of MoC will require a new breed of CME. It must be practice-based, evidence-based and relevant to the individual physician. Academic CME professionals should be leaders in delivering "continuous" education based on adult learning theory and quality improvement.

Challenges

At a time when we need to be most creative, medical schools and other organizations are slashing budgets. Perhaps that will stimulate our creativity. Is the education we now deliver efficient and appropriate to meet the new needs of physicians? Delivering more self-directed CME with limited resources will require new ways of thinking about our programs. The paradox of eliminating commercial bias while depending on commercial support continues to challenge CME providers. Now, more than ever, we need the support of our colleagues, collaboration, sharing of best practices, and research to provide evidence that what we are doing is the right thing to do.

Continuity

SACME's success is due to dedicated volunteers who serve on committees and in leadership positions. The leadership track allows for training time prior to becoming president. But it also allows for a team approach that has served us well. It has been my pleasure to work with the team for the past two years and I look forward to working with the new team this year. What diversity we have in our group! Jack Kues represents a medical school; Craig Campbell, a physician, represents Canadian medicine; Marty Hotvedt represents a health system; and I come from a specialty society.

We have a full slate of committee chairs and vice chairs in place to ensure continuity for our committees. Most chairs and vice chairs are working in teams as well. With most committees having open membership, there is plenty of opportunity for everyone to be involved in and contribute to SACME.

Communication

The key to success in any organization is effective communication. The relatively new Communications Committee, under the leadership of Jack Kues, has made giant strides in the past couple of years. Thanks to the diligence of Anne Taylor-Vaisey and Jim Ranieri, our website is a fantastic



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resource. Joyce Fried makes sure *Intercom* is a top-notch newsletter read cover to cover by members. The list-serve is a wonderful tool for disseminating timely information and sharing advice with our colleagues. I encourage all SACME members to subscribe to the list-serve and stay in touch.

SACME continues to be small enough to be friendly and mighty enough to have impact. I look forward to representing you in the coming year. Remember, communication is essential. I hope to hear from you. It takes all of us working together to make a difference.

THROUGH THE EYE OF THE DIGITAL CAMERA: SPRING MEETING PROVIDES SOMETHING FOR EVERYONE



The SACME Board of Directors concluded their board meeting on April 2 by posing for a photograph. Seated from left: Joyce Fried, Jack Kues, Ph.D., John Boothby, M.S.W., Craig Campbell, M.D., and Nancy Davis, Ph.D. Standing from left: Jim Ranieri, Melinda Steele, M.Ed., Bart Galle, Ph.D., Susan Duncan, M.Ed., Barbara Mierzwa, M.S., Michael Allen, M.D., Ellen Cosgrove, M.D., and Joan Sargeant, M.Ed.



BC Decker Inc., the publisher of *The Journal of Continuing Education in the Health Professions*, gives an annual prize for the best research article published in the journal. The winners were recognized at the Spring meeting in Santa Fe. From left, Nancy Bennett, Ph.D., Robert Kristofco, M.S.W., Linda Casebeer, Ph.D., Lee Manchul, M.D., and Paul Mazmanian, Ph.D., Editor of JCEHP.



From left, Michael Allen, M.D., Joan Sargeant, M.Ed., Research Committee Co-Chairs, and Jack Kues, Ph.D., President, present Michael Fordis, M.D. with the Fox Award while Robert Fox, Ed.D. observes. The Fox Award honors the research of Dr. Fox, University of Oklahoma, who has contributed greatly to the literature in the field of professional continuing education. Each year, the Fox Award is presented to the SACME member whose RICME abstract is judged best with respect to its methodology and impact on the profession. Dr. Fordis won the award for his presentation, "Internet-Based CME Instruction and Live Interactive CME Workshops Produce Similar Knowledge Gains about National Guidelines."



Two awards were presented at the SACME Business Meeting in Santa Fe on April 5, 2003. Richard Van Harrison, Ph.D. (pictured left) received the Research in Continuing Medical Education Award. The award is given to an individual who has made outstanding contributions to research in continuing medical education. Not present to receive the Distinguished Service in Continuing Medical Education Award was Robert Cullen, Ph.D. for his outstanding contributions to continuing medical education over an extended period.

SARS AND THE CME DIRECTOR

By Dave Davis, M.D., C.C.F.P., F.C.C.P.
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The Morning Alarm

March 27, 2003. The 6 am radio alarm was no surprise. What was a surprise was the opening item on the news—not the Iraqi war, but a new problem—SARS, or severe acute respiratory syndrome. My day, week and ultimately the next month went rapidly downhill—much less of course than that of many patients, members of the public, public health authorities, hospital and other health care workers, and others. This is the story of SARS in Toronto, its immediate consequences for us, and its possible implications for CME providers.

SARS and Its Impact on CME

SARS had started in China several weeks before, not fully understood at its outset as a highly lethal and extraordinarily communicable disease. In early March, a Canadian woman and her son, returning from Hong Kong, arrived in Toronto very ill. In rapid succession, they were transferred to a local community hospital, then to teaching hospitals, and the disease spread to several hundred others, many in the hospital setting itself. The ripple effect of this relatively small event was enormous and is well documented: to date nineteen have died,¹ several thousand quarantined,² hospitals closed to all but urgent cases,³ a public health ban has been instituted on health professional meetings,⁴ and a WHO proscription has been issued on travel to Toronto.⁵ For CME, the consequences were enormous: courses cancelled (ten to date) or postponed (five). When public health authorities gave us permission, we held two courses with restrictions—hand washing, SARS alerts, and a SARS screening tool.⁶ We are still trying to get back on our feet with the fear of SARS the serious heavyweight, not SARS itself.

While my main objective is to describe some of the immediate lessons learned in response to SARS for CME at the University of Toronto, I will also try to sketch the wider implications for continuing education in the face of bioterrorism and other disasters, and maybe even the implications for the shape and scope of CME itself.

Lessons Learned (The Short Term)

Remember your client. Our first thought was for the health professional learner's (our primary client) ability to attend conferences, and the attending fear for self or family. Pretty quickly, we acknowledged his/her right to make such personal decisions based on circumstances and concerns, and we determined that no financial penalty be applied to cancellation.

Information is everything. Early in the process, the CE Office recognized that the over-riding concern in decision-making was accurate risk assessment information: to this end, a reasonably close and regular relationship with Public Health was necessary. We consulted with local and provincial offices of health and safety on a regular basis, reporting their recommendations to course directors, department chairs, registrants, and other faculty members. If information is everything, so is communicating it.

Learn to tightrope walk. Given that the decision to cancel or proceed with a course is multi-factorial, we implemented a case-by-case decision-making process. The following factors were weighed: the expressed concerns of the registrant (demonstrated by registration cancellations and/or direct communications) and of the planners, current public health directives, the nature (specialty, practice setting, location) of the course attendees and their subsequent risk of exposure to SARS, and the logistical possibilities of postponing courses.

Take care. In those instances in which we decided to proceed with a course, Public Health recommended the following precautions: the prominent display of a SARS public health notification; the completion by each registrant of the SARS screening tool;⁶ the use of daily hand-washing with appropriate agents; and, where indicated, more aggressive protection such as taking routine daily temperature of each registrant and/or requiring each to mask.

Beat Catch 22. What if you had a new disease that required immediate education and yet which prohibited holding traditional large-group conferences? That's the story of SARS. Given the advent of communications and distance education technologies, we have started to really consider the use of alternative learning methods. In the short term, this might mean the use of teleconferencing technologies to "bring in" speakers unable to travel to Toronto, or the development of a CME website (www.cme.utoronto.ca) to spread the word. In the longer term, we are urging the use of alternative technologies as adjuncts or major tools in CME planning: web-casting technologies are the first, but by no means the only, entry on this list.

CME and SARS: Long-term Lessons

SARS may have delivered a body blow to our ability to deliver traditional continuing education courses and conferences, though clearly not a fatal one. This fact, however, is trumped by broader implications, first, beyond the clinical area of SARS, and second, beyond the scope of traditional CME itself.

Beyond SARS. While SARS has been the primary force for change experienced by the University of Toronto, our experiences suggest that CE providers need to prepare themselves to respond to similar public health challenges such as other infectious disease outbreaks or agents of bioterrorism. Here, the need for a strategic “disaster plan” approach means that varied and immediate means of communication assume greater need: web-based advice to physicians for example, or fan-faxed communication devices to our clients would have helped us, and might help in similar situations.

Beyond traditional CME. Now, a month after that day my alarm went off, we know a fair bit about SARS and believe that Toronto is a very safe CME site. There are still numerous questions, however, many with implications for CME. Why did SARS enter the Toronto community so readily? Did the providers of physician information (the University of Toronto included) miss the boat? Were guidelines adopted by the WHO not readily applied? If so, what does this mean for continuing education and the broader field described as “knowledge translation”,⁸ a way of thinking about CME that stresses the outcome rather than the process – that knowledge is transferred into practice in a timely and efficient manner?

I will leave you with this final head-scratcher. Is it possible that SARS and its ripple effect might, at long last, move continuing education from a conference-based, passive and reactive non-system, to a multi-modal, active and systematic medium by which to ensure appropriate and timely clinical practice? At the very least, the SARS outbreak has caused us in Toronto to contemplate a “new” CME; at the most, a clear promise to never be surprised again.

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I'd like to express my thanks to Laure Perrier for her efforts in referencing this article and, particularly, for her innovative management of the CE website (www.cme.utoronto.ca) through the SARS crisis.



PUBLISHING MEDICAL EDUCATION RESEARCH: SOME TIPS FOR SUCCESS

By Ann Steinecke, Ph.D., Deputy Editor,
Academic Medicine

Publishing medical education research is a difficult but necessary undertaking for scholars who want to communicate their research to their peers. Medical education journals are experiencing large increases in manuscript submissions, which has led to intense competition. For example, *Academic Medicine* currently accepts fewer than 20% of the research manuscripts it receives. Journal editors must often decide which one of a number of very good submissions on a similar topic is the best manuscript to select for publication.

The chances of your publishing medical education research today, as always, depends on your conducting a solid study, being organized, and knowing a few details about the process of scholarly publishing. If your professional advancement depends, even in part, on publishing your scholarship, I hope you will find that the following tips build on many of the writing skills you already have, and that you can put them into practice fairly easily.

Know the Journals in Your Field

Bordage¹ found that 13% of the manuscripts in that study were rejected because they were submitted to the “wrong journal.” With a minimal investment in time, you can save yourself several months of waiting to be told that your manuscript is not suited to a journal. Savvy authors know the journals in their field and tailor the preparation and submission of their reports based on that knowledge.

Keep profiles of the content, publication process, and reputation of any journal you would like to have publish your manuscript. Much of this information can be learned from scanning tables of contents, abstracts, and information for authors. Ask yourself about.

Content

- ✱ What is the scope of the journal?
- ✱ What types of articles are published?
- ✱ How often do you find articles that interest you?

Process

- ✱ How long will it take to receive a decision?
- ✱ What are the general characteristics of the journal's review process?
- ✱ What are the submission requirements?

and Reputation

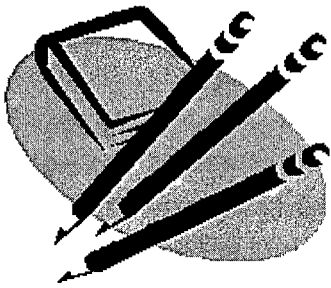
- ✱ What is the reputation of the journal among your colleagues?
- ✱ How often do you use the journal in your own research?
- ✱ Is the journal widely available?
- ✱ What is the journal's impact factor, “a measure of the frequency with which the ‘average article’ in a journal has been cited in a particular year or period”?²

By keeping profiles of the journals in your field, you can streamline the preparation of your manuscript. Also, in the event that your manuscript is not accepted by your first-choice journal, such profiles will allow you to quickly determine the next-best choice and send the manuscript back out for consideration.

Write to Communicate Clearly

The first audience member to read your report is likely to be the journal's editor-in-chief. The second, third, and perhaps fourth audience members are probably going to be the peer reviewers selected for your manuscript. Editors-in-chief tend to maintain a “ten-thousand-foot” perspective on their journal's content. Peer reviewers are carefully selected because of their expertise on specific topics. Teams of reviewers are often carefully formed based on the different perspectives they bring to the topic of the manuscript. One may be an expert in method, one may contribute comments on the practical implications of the study, and one may be asked to contribute a more general overview of the importance of the topic. For obvious reasons, it is important that all of these audience members be able to read your manuscript, understand how you conducted your study, and feel as confident as you are about the inferences you draw from your data. No matter how excellent your study is, these goals will be attained only if your manuscript is clear. Ultimately, if your manuscript is accepted for publication, your audience will broaden exponentially, but the goal of clarity will not change. The following three tips can help you achieve this goal.

Use jargon judiciously. Jargon is insider language. It can be a useful shortcut and, to those in the know, using it can be the most direct form of communication. To other readers,



however, jargon can be a barrier to understanding—even in a manuscript that contains useful information that is widely generalizable. When preparing a manuscript for publication, carefully weigh the benefits of using jargon against the risk of

limiting the audience you can potentially reach.

- ✱ Assume your audience is educated and knowledgeable but that not all readers are specialists in your field. Define jargon as language non-specialists will have to look up. Use it sparingly.
- ✱ When in doubt, add a brief definition (parenthetical definitions work well)
- ✱ Have someone outside your specialty read your manuscript for clarity.

Use terms consistently. Academics are poised to read critically. Serving as a peer reviewer can function as a kind of steroid to an academic. Efforts to ease their journey through your manuscript with artful shifts in language can sometimes backfire. Err on the side of caution and choose clarity over art. If you begin your manuscript with a discussion of “physician—educators,” do not switch to “preceptors,” “clinician—educators,” or any other descriptor just because you do not want to use the same term more than once in a paragraph. Have a clearly stated reason for making the change or do not make it. When encountering inconsistency of this sort, peer reviewers may detect significant differences where you do not intend them, which may lead them to misunderstand your method and undervalue your findings. Therefore, choose the most accurate term and use it consistently, or clearly explain any necessary shifts in terminology. Remind yourself that clunky-but-clear writing is preferable over artful but opaque writing.

Use the active voice. For a long time, the standard for scientific writing had been the passive voice. Research happened. Results were found. Eliminating the active voice de-emphasizes the role of the researcher and creates a tone of objectivity—a gold standard for empirical enquiry. But, it is more natural, clearer, and more concise to write with an active voice. Here is an example. Compare,

“If students with insufficient knowledge could be identified early in the clinical clerkship, an intervention could be undertaken with the students before the final examination,” with

“If instructors could identify students with insufficient

knowledge early in the clinical clerkship, they could intervene before the final examination.”

In the first example, which uses the passive voice, it is not clear who should be identifying students and who should perform the intervention. In the latter example, using the active voice requires that these questions be answered, and despite the additional information, the sentence is still five words shorter.

Care for Your Method Section

Most readers actually scan strategically rather than read entire reports. When a reader does linger, it is usually over the tables and figures (the “pictures” of data) and the method. Of the 77 review criteria developed by the RIME/GEA-Academic Medicine Task Force, 28, or over one-third, directly address the content of the method.³ And, in the growing literature on improving the quality of research being published, the focus has been on improving the methodological standards.⁴⁻⁶ The reason is clear—the method establishes the validity of the study’s results. The risk of a fatal flaw is greatest in the method. Ten percent of the manuscripts in the study by Bordage were rejected due to “incomplete method.”¹ Much of what peer reviewers interpret as fatal flaws within the method can be remedied by the author simply providing more information or clarifying the information already provided.

Beyond involving a professional researcher in the design of your study, which is a foregone recommendation, the precision of writing in your method section will assure reviewers and readers that your findings can be trusted

- ✱ Organize the elements of your method section chronologically, and in your first draft at least, use journalism’s guidelines of who, what, where, when, and why to describe the study’s design
- ✱ Make sure your description of the development of instruments, data sets, samples, and data analyses is complete.
- ✱ Include descriptions of any pilot tests, special training (e.g., for raters, data collection), etc.

End with a Bang

The discussion section provides the opportunity for you to explain the implications of your study’s findings and explore their practical applications. It is a chance to show readers connections between your work and the existing literature and guide them in furthering the research. The discussion is that

section of the research report where your writing—its tone and format—can be used to influence the reader.

- State the implications of your findings with confidence, but do not overstate them.
- Do not neglect to explore the implications of unexpected findings.
- Engage in a dialogue with relevant literature—even if you did not raise the literature in your introduction.
- Be explicit about what further studies are needed.
- Avoid opening the discussion with the limitations of your report, but do not neglect to include them.

Closing Thoughts

Preparing and submitting a manuscript to a scholarly journal can produce considerable anxiety. You have put a tremendous amount of work into your research; in many cases it has taken months if not years to complete. It is likely that you have worked with a team of authors, which presents its own challenges. I hope the tips I have discussed here will be helpful to you at those final and critical stages of manuscript

preparation and submission. By carefully preparing your manuscript to maximize communication and selecting the most suitable journal, you can improve the chances that your painful wait will result in the decision for which you were hoping.

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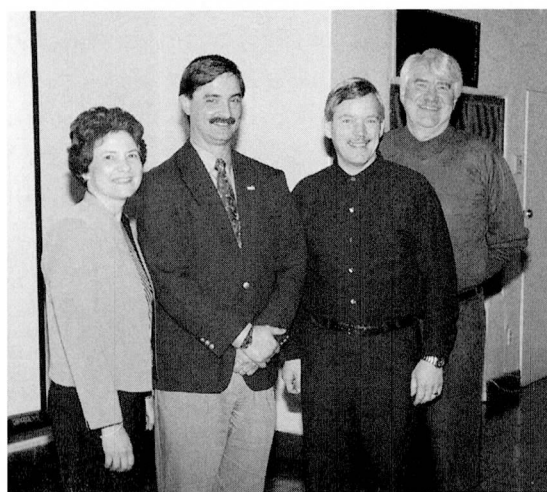
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SACME FOUNDING PRESIDENT RETIRES

By Joyce M. Fried

Phil R. Manning, M.D., founding father of the Society for Academic Continuing Medical Education, retired on June 30, 2002. He had been responsible for continuing education for practicing physicians at the University of Southern California (USC) since 1955 and since 1981 was Paul Ingalls Hoagland Hastings Professor of Continuing Medical Education.

Dr. Manning received his B.S. and M.D. degrees from the University of Southern California. He completed an internship at the Los Angeles County/USC Medical Center; a residency at the Veterans' Administration Hospital in Van Nuys, California; and a fellowship at the Mayo Clinic in Rochester, Minnesota. He is board certified in internal medicine and family medicine. He began his academic career at USC in 1954 as an Instructor of Medicine and rapidly climbed the academic ladder.

Dr. Manning's passion for CME developed long ago. For decades, he was convinced that the most important education for physicians occurs after residency. He said, "So many wonderful developments both in diagnosis and management make it mandatory for the practicing physician to be a lifelong student. Our job in CME is to facilitate the physician's desire to offer the best patient care."

He served as first president of the Society, then called the Society of Medical College Directors of CME, in 1976 and 1977. Asked how it feels to be the "founding father" of such a vibrant and vital society, Dr. Manning replied, "I have met so many good friends and colleagues in the Society that I am most appreciative of its existence. Certainly it is a platform that facilitates learning from each other." Dr. Manning recounted the early days of the Society in an article he wrote for the June, 2001 issue of *Intercom* on the occasion of the Society's 25th anniversary.

Regarding the future of CME, Dr. Manning said, "CME has been locked in the classroom setting almost from the beginning. Conferences and courses do, in fact, alert the physicians to advances in medicine and help them to review fundamental concepts, and I believe they always will be valuable. I hope that the classroom approach can be supplemented by methods that help the physician to systematically learn more from the practice experience. This will require simpler methods of data collection on real events in practice, still more efficient ways



From left, Dennis Wentz, M.D., Richard Van Harrison, Ph.D., Phil Manning, M.D. (honoree), and Jack Kues, Ph.D. pose at the Spring SACME meeting after Drs. Wentz, Van Harrison, and Kues presented Dr. Manning with a memory book from SACME.

to provide short answers to specific questions while seeing patients, and electronic reminders to help avoid errors of omission. Most of this will require an electronic medical record. In addition, more interest and enhanced motivation for the study of practice will come about when physicians have the opportunity to discuss actual practice data with respected colleagues."

Asked why people should support and become involved in SACME, he replied, "SACME really is the way that all of us in the field can help each other learn. The collegial relationships and friendships that come about through SACME add fun and enrichment to all members."

Dr. Manning has not yet thoroughly explored all the possibilities of enriching the retirement experience. He has several personal and family projects he is working on and is beginning to proofread the galley of the second edition of *Medicine: Preserving the Passion*. There are several family trips being planned as well.

His contributions of knowledge, teaching, writing, research, and leading by example are the legacy he has given the world of continuing medical education. Those of us who have had the pleasure of knowing him unanimously agree that he is a true gentleman.

NEWS FROM THE AMERICAN MEDICAL ASSOCIATION

THE END AND A BEGINNING: EDUCATIONAL CAMPAIGN ON GIFTS TO PHYSICIANS ENTERS PHASE II

By Dennis K. Wentz, M.D.

All Society for Academic Continuing Medical Education (SACME) members are undoubtedly well aware of the AMA-led initiative to create awareness among physicians and physicians-in-training about the ethical implications of receiving gifts from industry. It is hard to believe that the effort began in 2001. The National Task Force on CME Provider/Industry Collaboration acted on recommendations brought forward by a subcommittee chaired by Dr. R. Van Harrison, a former president of SACME. That report called for increased awareness by all concerned about the principles in the AMA Council on Ethical and Judicial Affairs Opinion 8.061, "Gifts to Physicians from Industry." Reacting to a challenge by an industry member of the task force, a 30-member national Working Group for the Communication of Ethical Guidelines on Gifts to Physicians from Industry (Working Group) was created. Several subcommittees of the Working Group outlined and launched the design of the national educational campaign. It is indeed gratifying to announce that Phase II of the campaign is ready for prime time.

There were some stormy times during the intervening months. Sensational stories about the influence of industry, most often pharmaceutical companies, on physicians and inappropriate gifts from industry appeared on an ongoing basis in major media. The sincerity of the campaign was questioned, since industry contributed both funding and intellectual resources to its development. It is interesting to note that from the beginning, the campaign was intended to create awareness not only in doctors but also in industry sales representatives.

Phase I of the initiative was labeled the Awareness Phase and has succeeded beyond our wildest dreams. Approximately 500,000 pocket cards describing the Ethical Opinion have been distributed free to anyone requesting them. An exhibit has traveled to major conferences and conventions, countless presentations have been made, and supportive op-ed pieces and editorials have appeared in the literature. In 2002 the Pharmaceutical Research and Manufacturers of America Association (PhRMA), which was involved from the beginning in the Working Group, issued guidelines to its member companies in support of these ethical principles. Most recently, AdvaMed, the organization of medical

device companies, has finalized guidelines for its member companies.

Phase II is now being unveiled. It consists of a series of four on-line teaching modules available at www.ama-assn.org/go/ethicalgifts. Each module presents important general concepts, then uses gifts as the context to illustrate the idea. Every module is rich with case examples. We believe that the educational modules will also help satisfy new requirements from the Accreditation Council for Graduate Medical Education (ACGME) for education on professionalism as one of the six competencies expected of residents in training.

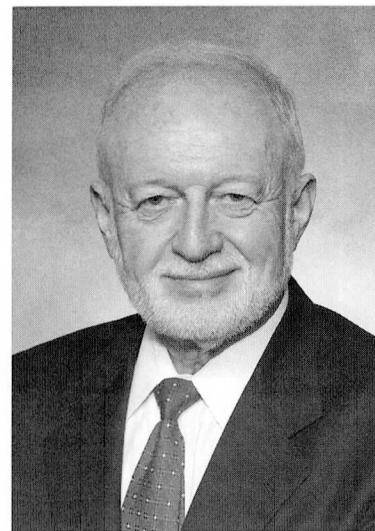
The four educational modules coming on-line over the next several weeks are:

- An overview of ethical, professional and legal issues for physicians' relationships with industry;
- Physicians' expectations from industry and sales personnel;
- Professionalism, including the issues of gifts to physicians from industry;
- The American Medical Association guidelines on gifts to physicians from industry.

Using the Internet, 24-hour instant access, each module is available in two formats at no cost:

- **Downloadable resource materials** for instructors, at any level of medical education, to use to build one-hour learning experiences. Materials include a presenter's guide, PowerPoint® slides and a participant's handout. CME providers can adapt these resources for use in their local sites.
- **An on-line self-study version designed for individual learners**, designated for one AMA PRA category 1 CME credit.

The material in the educational modules is based on the AMA Ethical Opinion 8.061, "Gifts to Physicians from Industry," written in 1990, which is part of the AMA Code of Medical Ethics. There



are no new policies or guidelines in the modules. The modules also refer to the PhRMA guidelines, as well as those developed by other medical, industry and government groups, as appropriate, to give a broad-based understanding of the issues involved in the ethics of gift giving. The PhRMA code and others are very similar in spirit and substance to the AMA Ethical Opinion. The recent guidance to pharmaceutical and device companies by the Office of the Inspector General is provided as a reference

In summary, we believe the modules offer an in-depth perspective on the interaction between physicians and members of the pharmaceutical and medical device industries, provide useful guidance on decision-making, and discuss how physicians' ethical behavior affects the quality of the patient-physician relationship. They are intended to be available for many years, the AMA will maintain the site, and we will continue to welcome your comments and suggestions. We hope that members of SACME will find them useful and refer their colleagues to them.

THE RDRB - KEEPING YOU UP-TO-DATE

By Laure Perrier, M.Ed., MLIS
RDRB Manager

The RDRB (Research and Development Resource Base) is a literature database focusing specifically on continuing education in health and medicine. The scope and size of the database reflect the volume of research in continuing medical education and related fields. Over 12,000 references are housed on the RDRB (including journal articles, books, and conference abstracts) making this a valuable tool in facilitating research and development in CME and continuing professional development.

The RDRB is for educators and health professionals to assist them in their study of continuing education topics including:

- program evaluation
- physician performance
- change
- health care outcomes
- guideline implementation
- educational outcome research
- competency and performance assessment
- informatics
- faculty development
- numerous other issues related to continuing education in the health professions

Where Can I Find the RDRB?

The RDRB is housed at the University of Toronto Continuing Education website at <http://www.cme.utoronto.ca/rdrb>

Users have access to the RDRB in several ways:

- search on your own at <http://www.cme.utoronto.ca/search/>
- request a search by using the online form at <http://www.cme.utoronto.ca/rdrb/request.html>

Alternatively, the website offers other access points into the CME literature. By clicking on "Bibliographies", the literature can be sampled with listings of notable articles and books in topical areas of continuing education. This area of the website also provides links to home pages of journals such as *Academic Medicine*, *CMAJ*, *JAMA*, *Journal of Continuing Education in the Health Professions*, and *Medical Education*.

The Quality and Integrity of the RDRB

Beginning over twenty years ago as a hard copy review of approximately 200 papers in CME called "The impact of CME: an annotated bibliography", the RDRB has come a long way to reside comfortably in the electronic age. A quick check into the web traffic to the on-line version of the RDRB reveals that there have been over 400 unique visitors since January 2003 that have come to search the RDRB on their own.

Due to the diversity of research in the area of continuing education, the literature for the RDRB draws from various sources including Medline®, ERIC (Educational Resources Information Centre), CINAHL® (Cumulative Index to Nursing and Allied Health Literature), and EMBASE. As well, the business, sociology, psychology, and even the aviation literature (to extract citations for the topic of team communication), are accessed to build a powerful database of literature.

Use the RDRB for

- creating research proposals
- planning innovative CE strategies
- thinking through a theoretical base for educational activities

The RDRB is open for business 24 hours a day on-line, and help is only an e-mail away. For questions, help with searches, or any information related to the RDRB, please contact us at l.perrier@utoronto.ca

Newsletter of the Society for Academic
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UPCOMING EVENTS

July 25-26, 2003

CME: The Basics

Rosemont, Illinois

Website: www.acme-assn.org

July 27-28, 2003

Understanding ACCME Accreditation

Chicago, Illinois

Contact: Becky Flanigan (312) 464-2500

September 8-11, 2003

14th Annual Conference of the National Task Force
on CME Provider/Industry Collaboration

Chicago, Illinois

Contact: Regina Littleton (312) 464-4952

October 25-29, 2003

CME Leadership in the 21st Century

Duke University School of Medicine

Durham, North Carolina

Website: www.leadershipincme.com

November 7-10, 2003

SACME Fall Meeting

Association of American Medical Colleges

Washington, D.C.

Contact: Jim Ranieri (205) 978-7990

December 12-13, 2003

Understanding ACCME Accreditation

Chicago, Illinois

Contact: Becky Flanigan (312) 464-2500

January 21-24, 2004

2004 Alliance for CME Annual Conference

Atlanta, Georgia

Website: <http://www.acme-assn.org>

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