

# CME BRIEFING®

NEWS, OPINIONS, AND PERSPECTIVES IN CONTINUING MEDICAL EDUCATION • JULY-SEPTEMBER 2003

## ACCME's Chief Accreditation Surveyors: Helping to Ensure Quality Control and Process Improvements

*In March 2002, the Accreditation Council for Continuing Medical Education (ACCME) appointed John Jurica, MD, and Mark Schaffer, EdM, as the Council's first Chief Accreditation Surveyors. CME Briefing recently met up with them and Kate Regnier, MA, MBA, Deputy Chief Executive at the ACCME, to learn more about the position of Chief Surveyor, its role within ACCME, and the importance of the role to the CME provider.*

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*How is SACME helping to maintain physician competence?*

Chief Surveyors: Mentors at the Helm of the Volunteer Surveyor Pool  
"The position of Chief Surveyor was created as an additional resource for the ACCME to maintain the quality and consistency of the survey process," Regnier told *CME Briefing*. "A direct benefit to the provider is the quality of our surveyor pool," continued Regnier, "and Chief Surveyors are also helping us ensure that quality."

That surveyor pool is over 100 strong. Last year, ACCME conducted 275 surveys with volunteers "matched" to the type of organization they were surveying. Regnier explained, "It is critical that we have surveyors who represent all types of organiza-

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## Gearing Up for Congress 2004: Turning Knowledge Into Practice

Recognizing that improved healthcare outcomes depend on an unbroken chain between information, education, and implementation—and knowing that the CME professional may be involved in any of these links along the chain—Congress 2004 will provide a forum for understanding the translation of knowledge into practice to achieve desired outcomes. The Congress is cosponsored by The Alliance for CME, The Society for Academic CME, and The Association for Hospital Medical Education, in association with the University of Toronto and the Canadian Association of Continuing Health Education. (See calendar for details.) This year, the North American Association of Medical Education and Communication Companies (NAAMECC) is also a cosponsor of the Congress.

"'Knowledge translation' is a new code phrase for us," Dave Davis, MD, CCFP, FCFP, chair of Congress 2004, told *CME Briefing*. Davis is Associate Dean for Continuing Education at the University of Toronto, which is hosting the Congress, the fifth such meeting in the past 20 years. Davis continued, "It is not just that the physician acquires knowledge, but that he or she uses that knowledge in an appropriate, timely fashion, and applies that knowledge in such a way that healthcare outcomes are improved." In other words, it looks at the end product of more broadly defined continuing education strategies. It looks at the outcome instead of the process.

The CME community in general (CME-related associations and CME providers) is

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# CMEBRIEFING®

CME BRIEFING is published by Thomson Professional Postgraduate Services® (PPS), a division of Thomson Physicians World. The mission of this newsletter is to disseminate news and information about CME and to foster dialogue among the concerned parties, including the medical profession, government, industry, and CME sponsors.

PPS is dedicated to health-related education for physicians, para-professionals, and patients.

Thomson Professional Postgraduate Services® is accredited by the ACCME to provide continuing medical education for physicians.

We are proud of our 30-year history of medical publishing, and feel a responsibility to enhance medical education by improving communication among interested parties. Our proactive relationship with the government, the medical profession, industry, and CME sponsors will benefit from the input of our readers. Please send comments or questions about this newsletter to the CME BRIEFING Editor.

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## T O T H E E D I T O R

The latest issue of *CME Briefing* contains an interesting summary of the many different factions involved in commercial support. I was most impressed, however, by the provision of a link to NAAMECC's response to ACCME's draft. And by the printing of the response of the American College of Rheumatology.

In the interest of full disclosure, I believe ACCME should publish all the comments it received. Were there 5 responses? 50? 500? Let me, an accredited provider, be the judge of which were favorable and which were not. Let me, an accredited provider, be the judge of those FAQs so conveniently posted on ACCME's website. By what criteria were those questions chosen? What was left out? Let me decide. Give me the information and I will form my own opinion.

I recently attended a meeting of the Northeast Consortium of Medical School CME Professionals at which Murray Kopelow, MD, was the featured speaker. The issue of disclosure was presented, although hardly resolved. Talk centered around "managing the perceived conflict of interest." What does that mean? And, who will do it?

My major concern is one evidently shared by NAAMECC. And that is, unless all providers interpret these guidelines the same way, there will continue to be "shopping" for the provider who puts up the fewest barriers. This isn't good for anybody.

Janice L. Miller, MEd, CHES  
*Director of Continuing Medical Education*  
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**Publisher's comment:** In the last issue of *CME Briefing* we published responses of a few organizations to the draft of the ACCME Standards for Commercial Support. These responses were not specifically selected, but were published (or a link provided) because the organization gave us the information. *CME Briefing* would be more than happy to publish (space permitting) or provide links to the comments of others in the interest of sharing information with our readers. Send your comments to [PPSCME-Editor@pwcg.com](mailto:PPSCME-Editor@pwcg.com).

Mark Schaffer

# ACCME's Chief Accreditation Surveyors: Helping to Ensure Quality Control and Process Improvements

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tions that we accredit. If we are going to survey a medical school, we make sure at least one member of the survey team has medical school experience. Although we may have 100 surveyors, they might not have the necessary background to survey all types of providers."

Surveyors are not only matched to the task at hand but also adequately prepared. Regnier explained, "When new surveyors are brought on board, they go through an extensive training process, and the Chief Surveyors participate as faculty." Volunteer surveyors are required to conduct at least one survey a year to keep current, and to participate in ongoing surveyor training sessions.

"The Chief Surveyors are the faculty/mentors for many of the surveyor training activities we conduct," Regnier continued. This includes an annual surveyor update meeting that takes place during the Alliance meeting.

## Improving the Quality of the Survey Process

But the role of Chief Surveyor goes well beyond training. Jurica and Schaffer also serve as advisors for the survey process itself, making sure that surveyors are bringing back the type—and depth—of information needed by the ACCME's Accreditation Review Committee (ARC) in order to make a decision on the CME provider's accreditation.

"The surveyors are advocates for the provider," said Regnier, "making sure that the ARC has what it needs to make an accreditation recommendation." So the survey process is essentially a data-gathering process, but the Chief Surveyors ensure it is a *quality* process.

They have assisted with a review of the data-gathering instruments—to be sure each instrument is getting at the data needed for a fair and accu-

rate recommendation by ARC on accreditation. They also identify areas that are missing from the survey process, and they recommend ways to improve it. Regnier noted, "The Chief Surveyors are helping us to identify where we need more facts, more information, or where we need to ask better questions. The idea is always to improve the process for the benefit of the provider."

they operate; they know the ARC and what it needs. They know CME from every perspective; they know what a quality survey process means. "Our role is to help in process," said Jurica. "It leads to consistency and validity, which obviously benefit the CME provider."

## The Days of Yore

The survey process has certainly refined itself over the years, and with this comes less subjectivity and more objectivity (consistency). Although it is essentially a data-gathering process ("Just the facts," said Regnier, meaning that surveyors do not make the actual decisions on accred-

## About the Chief Accreditation Surveyors

**John Jurica, MD**, is a practicing family physician in Kankakee, Illinois, and Vice President of Medical Affairs at Riverside Medical Center, where he has served as Chair of the CME Committee. A member of the Illinois State Medical Society CME Committee for 9 years and Chair for 5 years, Dr Jurica served on the ARC for 6 years, taught as faculty at the ACCME workshop, and has been an ACCME Accreditation Surveyor for 4 years.

**Mark Schaffer, EdM**, is currently Vice President, CME, at Thomson Professional Postgraduate Services®, a division of Thomson Physicians World in Secaucus, NJ. Previously, Mr Schaffer was Executive Director for CME at the University of Medicine and Dentistry of New Jersey. He has been an ACCME Accreditation Surveyor for 8 years, and has served as a faculty member at the ACCME Workshop and as a member of the ACCME's Monitoring Committee.

"I've seen this over the years at the ACCME and within the ARC," said Jurica. "They have tried to continually improve the objectivity, fairness, validity, and consistency of the process."

Collectively, Jurica and Schaffer have decades of complementary and collaborative experience in CME (see *About the Chief Accreditation Surveyors*). Regnier added, "They were selected because of their demonstrated commitment and abilities as surveyors. But the fact that they represent a range of the provider types, as well as the physician/nonphysician aspect, was valuable to us."

Essentially, these particular Chief Surveyors know surveys and how

itiation), surveyors need to be careful about *how* they collect the data.

"The change in the training from the time that I started to now is amazing," said Schaffer. Volunteer surveyors, in addition to data gathering, are trained in:

- How to approach a survey
- How to handle a difficult survey
- How to interact with providers
- How to ask questions
- What questions are appropriate—and not appropriate
- Writing surveyor reports, aiming for consistency across reports and between surveyors in language and how they communicate back to the ARC.

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## Inside the Minds of Jurica and Schaffer

Together they've looked at CME from nearly every perspective, and they certainly know the issues. Given this background, experience, and insight, *CME Briefing* asked John Jurica, MD, and Mark Schaffer, EdM, Chief Accreditation Surveyors for the Accreditation Council for Continuing Medical Education: *What are the challenges facing CME providers today?*

**Jurica:** Most providers are facing budgetary challenges. They want to maintain and grow their CME program, but the funding for healthcare and the payment to providers are decreasing. Although the entire healthcare system seems to be growing in terms of demand and demographics, the funding for healthcare hasn't been growing as quickly. CME providers have to find out ways to maintain and grow their CME programs with less funding, either directly or indirectly.

Related to this is a second challenge. CME providers are trying to improve their productivity and efficiency, which often means using technology (computers, web-based systems, etc) that helps with planning, management, and implementation. Now they have to figure out how to develop some of those methods of efficiency and productivity while their budgets may be leveling off or decreasing.

**Schaffer:** The first challenge for the CME providers is the regulatory effect of what I refer to as "nontraditional regulators," more specifically, the Office of the Inspector General. Some of these issues will definitely impact CME and could also impact the CME providers.

Providers also need to find a way to measure outcomes, or the effect of their CME activities. This is important because all providers should be able to demonstrate that their activities are having a positive effect on the physician's practice of medicine. This leads into the third challenge, which is finding ways to make CME programs better. And when I say better, I mean more interactive (getting away from the total lecture format), where you really start to engage the physician. And that becomes a problem because, as John pointed out, everybody is operating under budget limitations. When you try to engage people in an interactive mode, you are talking about doing things that are a little more expensive, be it an audience-response system or utilizing a small-group approach. But the result of this type of approach is well worth the effort and the expense.

*Continued from previous page*

### From Inside ACCME

Regnier offered specific examples of how the ACCME calls upon Jurica and Schaffer. "The Chief Surveyors serve as a sounding board for surveyor training," she said. If the ACCME plans to roll out a new policy, for which volunteer surveyors will be asked to collect data, ACCME will ask the Chief Surveyors for guidance on how to integrate the collection of data about the policy in the survey process. Jurica and/or Schaffer have

been called upon to review the survey report forms (survey data-collection instruments) and answer the following questions for ACCME:

- Do you understand what is being asked on the data-collection instrument?
- Would you know where to get the information to answer this question?
- Would you know the questions to ask?

- Would this be enough data for the ARC to make a recommendation, or to provide evidence that a requested change has been implemented?

"With Dr Jurica a former member of the ARC," explained Regnier, "he knows what happens at that committee table, and he was able to bring to his role as Chief Surveyor his areas of concern about missing information. Mark was invited to a meeting of the ARC for a valuable exchange on areas where the surveyors could be asked to improve—ultimately to help ARC make more valid and consistent recommendations."

Initiated at the end of 2002, at the request of the Quality Improvement Committee of ACCME, the Chief Surveyors also review the new surveyor applicants to help determine their qualifications. "It is helpful for ACCME staff to have a second review by the Chief Surveyors," said Regnier.

### Complementing Perspectives With a Single Goal

The physician-nonphysician pairing of Jurica and Schaffer offers a major advantage.

Schaffer said, "John brings a lot to the position as a physician and as a provider. I would like to think that I bring a lot as an educator and a provider." Schaffer is quick to note that Jurica is indeed an educator as well, but their different perspectives on education provide a broader view that is so critical. "I've been around physicians a lot," continued Schaffer, "and I have ideas that are not necessarily the same as theirs. But you can get good ideas from different views. Because of this, John and I are a good complement."

But in spite of the differences in background and perspective, when it comes to the survey process, they have a single goal. "We want to facilitate the survey process," said Jurica, "so that consistent surveys are conducted, and surveyors are consistent and knowledgeable. We want to help them, and ultimately help the CME practice."

# Gearing Up for Congress 2004: Turning Knowledge Into Practice

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directing more of its focus to health-care outcomes, which is one reason Congress 2004 will explore this topic. Another reason comes from an even higher source. The Agency for Health Research and Quality has pointed out a sizable gap between "best evidence" and "actual practice" for different healthcare states. Davis explained where these gaps may occur:

- Is there a lack of knowledge?
- Is there knowledge, but a lack of agreement with the information (perhaps because of regional or practice population differences)?
- If there is agreement with the knowledge, is it implemented in practice?
- If it is implemented in practice, is it done all the time?

## An Important Role for CME

"CME can fill the gaps," noted Davis, "but first it needs to redefine itself." By this, Davis explained that CME, at its core, is no longer defined as the short course given by a CME provider, or the postcourse materials mailed by a CME provider. "We have to look at *all* the tools that physicians use to learn and change, asking ourselves, 'What can we do in CME to affect physician behavior?' It means reaching out, and working together; it means thinking outside the box. That's the message of the Congress."

The tools of knowledge translation include small-group learning sessions, case-based learning activities, web conferencing, feedback systems, academic detailing (to reach those physicians previously unreachable), or training opinion leaders to deliver messages within a medical community, however that may be defined. No doubt, Congress 2004 will spark more ideas.

## A Preview of Congress 2004

Congress 2004 will include "block areas" with keynote speakers who will overview the issues related to:

- The broad healthcare environment, particularly in North America
- The internal healthcare environment, particularly maintenance of physician competence
- Education theory in CME
- Evidence-based medicine and informatics
- Implementing guidelines—putting it all together

But certainly the best feature of the Congress will be the interactivity planned for participants, or as Davis puts it, the "communities of learners." Within each of the block areas, the Congress is planning time for workshops both before and after keynote talks, where physicians, CME providers, policy makers, health services researchers, and other health professionals (all in the communities of learners) can come together to discuss practical applications of these concepts. According to Davis, workshop interaction will help like-minded learners answer questions such as:

- What/where are the gaps in my environment?
- How can I work with these concepts to improve education outcomes/patient outcomes?
- How can this be applied to the best effect in my setting?
- What will I do when I return to my CME milieu?

Interested participants can take part in other ways, too: as workshop leaders, small group discussion leaders, and poster or abstract presenters, and in research symposia as moderators, panelists, and discussants. Details of the meeting can be found online at [www.cmecongress.org](http://www.cmecongress.org). The website will be regularly updated as information about the Congress becomes available, including abstract and poster submission dates. A complete program brochure will be posted in January 2004.

And the interaction won't stop when the Congress ends. Davis said, "We envision our website as more than just an announcement brochure. We plan to build chat rooms and discussion areas where physicians and other participants can continue their relationships."

In emphasizing the value of Congress 2004, Davis said, "If you want to be the CME provider that is ahead of the curve, you have to take part in this Congress to meet your peers, learn what they are doing, learn about the latest developments in CME, and then to be able to take that back with you. I can't imagine practicing CME without it."

### ***Influences on the practice of CME are coming from some unlikely sources, including the Office of the Inspector General (OIG). Do you know about them?***

NAAMECC 3RD ANNUAL CONFERENCE

**"OIG-VEY! The Impact of Non-Traditional Regulators on CE"**

**Tuesday, September 9, 2003  
6:30 PM – 8:00 PM  
Chicago Hilton Hotel**

Panel discussion of the key issues will be led by John Kamp, JD, of Wiley, Rein & Fielding LLP. Panelists will include Michael Saxton, pharmaceutical industry consultant; Jo Ann Rice, AdvanMed, LLC; Olga Korytko, Medical Education Systems, Inc; and others.

For more information and meeting update, visit [www.naamecc.org](http://www.naamecc.org), News section.

# Individuality and Technology: SACME's CME Challenges

**W**ith physician competence a major goal for academic organizations, making sure that CME meets individual physician needs and that providers are fully utilizing all that information technology has to offer are at the top of the "To Do" list for SACME, the Society for Academic Continuing Medical Education. Participants in SACME's 2003 Spring Meeting—including CME professionals from medical schools, specialty societies, and government agencies—learned about SACME's perspectives, commitment, efforts, and challenges in these areas.

## Assessing the Issues

"When physicians finish their formal training, the majority of their association with medicine is still ahead of them," Jack R. Kues, PhD, told *CME Briefing*. Kues, Professor of Family Medicine, is Assistant Dean for CME at the University of Cincinnati, Ohio. He is also Past President of SACME and served as the Spring Meeting

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***"We have no formal training for physicians once they have finished their residency training, and we have only minimal ways of guaranteeing that they are continuing to be competent in those areas."***

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Moderator. "We have no formal training for physicians once they have finished their residency training, and we have only minimal ways of guaranteeing that they are continuing to be competent in those areas."

But the Association of American Medical Colleges, specialty societies, and specialty board organizations all are eager to demonstrate—

among themselves and to the public—that their physicians are competent to be practicing medicine. "The assumption has been that if you are board certified in a specialty, that's enough to indicate competence." But Kues is quick to note, "Now we are seeing a shift in our definition of competence."

## How CME Fits In

Kues echoed the sentiments of many organizations oriented to academic CME when he said, "We need to design CME to meet individual physician needs in the context of their clinical practice." He explained, "If you take a dozen family physicians, and you look carefully at their practices, you would find a dozen different definitions of maintaining competence." This requires a careful look at how things are being done and how they might need to change.

Some of the traditional CME activities are directed more to the masses than to individual physicians. Large lectures covering broad topics make it inherently more difficult to get to what Kues calls "the heart of individual doctors' practices." He said, "First we need to help the practicing physician develop the skills to identify their own needs, and then we need to provide them with mechanisms to get their educational needs met." Practically this means better self-assessment tools for physicians, and content—enduring materials, Internet-based CME, or interactive CME—that can be tailored or modified for individual needs. The goal: pinpointing knowledge deficits and targeting learning needs.

## The Challenges for SACME

This process for fine-tuning academic CME is dotted with challenges for SACME. As Kues noted, SACME will need to work with physicians to help them improve their self-assessment skills, as well as to develop the actual self-assessment tools, which

ultimately can be used to work with CME providers in developing activities that can be tailored to individual physician practices.

But SACME won't be working alone on this. No one entity could. "Recognizing that this has to be a collaborative effort across the licensing bodies, the specialty boards, the specialty societies, the medical schools, and other organizations is a very good first step," said Kues.

The next step, according to Kues, involves taking advantage of existing resources and skill sets. "Medical schools and specialty societies have a wealth of intellectual property available through their faculty and members," said Kues. "We need to develop evidence-based CME and other strategies for maintaining competence of physicians," he continued.

## Tackling Technology

Information technology—Internet, search engines, evidence-based medicine databases (which synthesize articles into practical information that can guide clinical decisions), and other online resources—plays a huge role in maintaining physician competence. It is no surprise that today's practicing physician is overwhelmed, given the number of patients to see, the business side of medicine, and the vast amount of new knowledge that becomes available every day. With journal reading no longer a viable model for remaining competent, Kues said, "Information technology has become absolutely essential to deliver the mountain of material to physicians in a way they can actually use." An information technology workshop was part of the SACME Spring Meeting. (See *The SACME Toolbox*.)

Kues noted, "More and more, we are trying to get resources into the hands of physicians precisely when a question arises with a patient, so they can alter or refine their decisions while the patient is still there." This is also known as point-of-care access to knowledge.

"From a CME perspective," explained Kues, "if physicians are learning while they are seeing

patients by using some of these resources, we believe that there should be a way to award CME credit to reinforce this type of behavior." As Kues envisions it, something "behind the scenes" is needed to document, for both the physician and the CME provider, what the physician was looking at, the amount of time spent gathering information, and ultimately what decisions were altered or what behavior changes took place as a result of the learning activity. It then would be up to the CME provider to designate credit for the activity.

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***"The model we are looking at," said Kues, "is one that combines new knowledge to change physician behavior with information technology that supports the efforts of the CME provider and ultimately the physician in practice."***

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"The model we are looking at," said Kues, "is one that combines new knowledge to change physician behavior with information technology that supports the efforts of the CME provider and ultimately the physician in practice."

This model would parallel those that exist on commercial websites. Visitors to these websites have their activities monitored in order to provide them with new information about products similar to those that they have been purchasing or searching for. Databases and monitoring software keep detailed records of everything the online customer does while at a particular website. Similar applications with links to clinical systems, such as order entry and billing systems, could provide a valuable tool for physician learning activities and corresponding clinical decisions.

## The SACME Toolbox

With CME playing a major role in the maintenance of physician competence, maximizing information technology resources will be critical for CME providers. During SACME's 2003 Spring Meeting, participants had a chance to attend a "tools and resources" workshop that covered information technology, evidence-based medicine resources, and a tour of the SACME website, to help them take full advantage of the most current information resources. The workshop was led by Jack R. Kues, PhD, and Anne Taylor-Vaisey, MLS. Taylor-Vaisey is Reference Librarian at the Canadian Memorial Chiropractic College Health Sciences Library, and she serves as SACME Web Editor, helping members learn more about the resources they need.

During this session, Taylor-Vaisey talked about various educational tools and research databases that are available to CME providers who are looking for research within CME and medical education. According to Kues, "It is incumbent on the CME professional to now become familiar with all the literature, which is a much broader base than we were examining before." Lucky for CME providers of all types, the SACME website offers one-stop shopping for many of these tools.

Visit [www.sacme.org](http://www.sacme.org), click on Take a Tour, and explore. Or choose the Research Roadmap and view the collection of sites and sources that have been assembled for CME professionals. Included in the Research Roadmap are links for:

**Medical Education Literature:** Reference lists of continuing education articles, education databases, continuing education conference abstracts, journals, and news sources for medical educators

**Medical Literature:** Medical databases and resources for evidence-based medicine and practice guidelines

**Medical & Health Resources:** Starting points, links to patient and drug information

**General Web Resources:** Starting points, links to sites for statistics, libraries, government, and law

**Tools for the Researcher:** Research grants, how to evaluate Web resources, how to keep up to date

**Tools for the CE Provider:** Associations in medical education, accreditation and maintenance of certification, continuing education events and conferences

SACME is one organization helping all of us tackle technology and make it work for CME—building a powerful partnership for the physician in practice.

# AMA International Approval Language

The AMA has received many questions and valuable feedback from CME providers regarding the recent policy on the awarding of AMA PRA category 1 credit to non-US licensed physicians. A common question was, "What language can be used on promotional materials to indicate that non-US licensed physicians are eligible for AMA PRA category 1 credit?"

On any marketing pieces or agendas for activities designated for AMA PRA category 1 credit, providers must print the designation statement as published in the AMA Physician's Recognition Award: Requirements for Accredited Providers booklet. Additionally, for activities that have been approved for non-US licensed physicians, providers should include the following supplemental language — immediately after the designation statement and with a line break — on program materials:

"The American Medical Association has determined that non-US licensed physicians who participate in this CME activity are eligible for AMA PRA category 1 credit."

Like the AMA's guidance regarding the designation statement for "save the date" announcements, providers may not indicate that "Approval for non-US licensed physicians has been applied for."

For an example on how to use this language in conjunction with the designation statement on approved activities, and for answers to other questions the AMA has received from providers, please visit [www.ama-assn.org/go/intlpra-credit](http://www.ama-assn.org/go/intlpra-credit) and click "Frequently Asked Questions."

*From the AMA Division of Continuing Physician Professional Development, News Briefs, April 3, 2003.*

## FOR YOUR CALENDAR UPCOMING CME MEETINGS FOR CME PROFESSIONALS

14th Annual Conference of the National Task Force on CME Provider/Industry Collaboration "Partners in Progress: Serving the Professions and the Public"

September 8–11, 2003  
Chicago, IL

For more information, contact:  
Regina Littleton  
Phone: 1 (312) 464-4637  
Email: [regina\\_littleton@ama-assn.org](mailto:regina_littleton@ama-assn.org)

3rd Annual Meeting of the North American Association of Medical Education and Communication Companies (NAAMECC)

September 9, 2003  
Chicago, IL

For more information and meeting update, visit website: [www.naamecc.org](http://www.naamecc.org), News section

Duke University Office of Continuing Medical Education and Thomson Professional Postgraduate Services® "CME Leadership in the 21st Century: A Case-Based Conference for Current and Future Leaders in Continuing Medical Education"

October 25–29, 2003  
Durham, NC

For more information, contact:  
Duke University Office of CME  
Phone: 1 (800) 222-9984  
Fax: 1 (919) 681-7462  
Website: [www.leadershipincme.com](http://www.leadershipincme.com)

Alliance for Continuing Medical Education "29th Alliance for CME Annual Conference"

January 21–January 24, 2004  
Atlanta, GA

For more information, contact:  
Alliance for Continuing Medical Education  
Phone: 1 (205) 824-1355  
Fax: 1 (205) 824-1357  
Website: [www.acme-assn.org](http://www.acme-assn.org)

The Alliance for CME (ACME), the Association for Hospital Medical Education (AHME), and the Society for Academic CME (SACME) "CME Congress 2004"

May 16–19, 2004  
Toronto, Ontario, Canada

For more information, contact:  
Conference Secretariat, University of Toronto  
Phone: 1 (416) 978-2719; 1 (888) 512-8173 (toll-free North America only)  
Fax: 1 (416) 971-2200  
Website: [www.cmecongress.org](http://www.cmecongress.org)

## Want a Hot Tip on a Good Investment?

"Invest in your CME career," advise cosponsors Duke University School of Medicine and Thomson Professional Postgraduate Services®, and they provide you with the means to do it at *CME Leadership in the 21st Century*, to be held October 25–29, 2003.

This is a highly interactive, thought-provoking conference. It offers not only expert guidance but also information that every CME leader should know concerning issues that affect the implementation, operation, and management of CME activities and programs.

The program, which began in 2002, had such an overwhelming response by participants that the decision was made early on to repeat the event, especially because the issues keep evolving at a constant, and oftentimes rapid, pace. But as a leader, it is important to keep up.

According to Joseph Green, PhD, Associate Dean for CME at Duke University School of Medicine in Durham, North Carolina, the 2003 conference will be similar to the past conference, but with more faculty members to discuss the regulatory issues that are affecting CME today. "It is the most comprehensive session you can get if you are planning on being a leader in the CME world," said Green, "and it offers the opportunity to interact with other leaders."

Make your fall conference plans now. Visit [www.leadershipincme.com](http://www.leadershipincme.com) for a description of the 2003 conference and its objectives, and to apply for admission. The site also provides the presentations from the 2002 conference and feedback and reviews from that year's participants.

With all it has to offer, *CME Leadership in the 21st Century* is an investment you can count on!