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GAME NEWS

Volume 3 • Number 2 • 2001

THE OFFICIAL NEWS ORGAN OF THE GLOBAL ALLIANCE FOR MEDICAL EDUCATION

Featured in This Issue

Keynote Speaker Martin Cearnal, Physicians World/Thomson Healthcare (far right), talks with GAME Annual Meeting attendees.

Sixth Annual GAME Meeting

International CME Faces Growth and Challenges: Keynote Speaker

By Tamar Hosansky, Editor, Medical Meetings *Magazine*

"If education looks like promotion, it will get regulated like promotion. If education uses gifts instead of content and faculty [to draw attendees]—it is promotion."

With that provocative statement, Martin E. Cearnal, President and CEO, Physicians World/Thomson Healthcare Group, Secaucus, N.J., kicked off the Sixth Annual GAME conference.

Held June 24 to 26 at the Princeton Club in New York City, the conference attracted more than 110 attendees and faculty from Europe, Asia, Australasia, Canada, Latin America, and South America, as well as the U.S. Not only is that a GAME record, but the conference drew more international delegates this year than last. Another sign of success: 75% percent of this year's attendees had also attended in 2000.

Cearnal sounded his cautionary note while also pointing out that the international CME enterprise augurs success, with investments in education increasing. But there are minefields ahead, he warned, as the relationships between pharmaceutical companies, physicians, and CME providers continue to fuel public, governmental, and media criticism. Witness the headlines in the U.S., for instance, about the so-called "dine 'n dash" meetings, and a physician-run Web site www.nofreelunch.org, which discourages doctors from having anything to do with pharmaceutical marketing. CME providers worldwide need to pay close attention to these U.S. warning signs, Cearnal said, because "if

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GAME President's Corner


Christopher West

I still remember what it was like in 1996 when I attended the first GAME (then known as the International Alliance for Health Education) meeting in Darien, Connecticut. We were a tiny band indeed—two dozen at most—each having been coaxed into attending by Lew Miller, with the proviso that we be prepared to make a short presentation on what we do. That's how it all began.

Though few in number, we had wide geographic representation at that first meeting, including people from Europe, the U.S., Canada, Latin America and Asia. We shared our insights with each other, made new connections and friends, explored potential alliances and business opportunities, and most importantly, concluded it would be good to hold this kind of meeting again.

The following year, the fledging organization grew and the annual meeting moved to the Princeton Club in New York. What had started in an informal way, became a larger, more "professional society" event. Attendance grew, as did the numbers of speakers and session themes. And that trend has continued ever since. But two essential factors have remained constant in the evolution of GAME: the international collegiality I experienced at that first meeting; and the priceless opportunities that arise when you can be elbow to elbow with CME experts and entrepreneurs from all over the world.

My father was a biologist, so it should come as no surprise that I am a great believer in the beneficial effects of cross-pollination. In my view, GAME, in a few short years, has become the queen bee of international CME…gathering and exchanging pollen from flourishing CME players and institutions from North, South, East and West. At this year's annual meeting we had over 110 attendees from Pakistan, the U.K., Belgium, Ireland, Mexico, Colombia, Brazil, Japan, Australia, Canada, the U.S., Germany and Spain. More than any other factor, it is this cross-fertilizing role that has inspired GAME's growth to date, and which I believe will guide our future. [With apologies to any beekeepers or entomologists, I fully acknowledge it is the worker bee, not the queen, who does the actual fertilizing!]

Notes:

- No volunteer-run organization like GAME, particularly in its infancy, can survive and prosper without the dedicated service of those who give generously of their time and resources. GAME is very fortunate to have been blessed with outstanding directors and officers from its inception. On behalf of the Board and the entire membership, I would like to pay tribute here to the leadership and vision of my immediate predecessor, Mark Connors, who stepped down as president this past June, and to departing directors, Don Nelinson, Pedro Vera Cervera and Nikos Kastanos. In turn, we extend a hand of welcome to new directors Celene Chasen, Pedro Vera Garduño and Toshiaki Shichino.

- Thank you to all who took the time to fill out evaluations at the conclusion of the June meeting in New York. There were two or three strands of constructive criticism, which I want to address here. First, there is the question of the Princeton Club itself. Many of you rightly observed that it was cramped quarters for a meeting of this size: hot, stuffy, the dishes were not cleared in timely fashion and so on. We hear you, and can only fall back on the excuse that GAME has been the victim of its own success. We have obviously outgrown the capacities of the Princeton Club. Future meetings, including next year's in Montreal, will be booked at larger, better-ventilated and more versatile venues.

  A related issue was the lack of breakouts. Many of you complained that we should be practicing what we preach—effective education—and allow the attendees to engage in a choice of smaller, more interactive breakout sessions. We agree. And at next year's meeting in the splendid mansion of the McGill Faculty Club in my hometown, Montreal, we will be taking full advantage of that facility's extra rooms and separate dining facilities.

  Thirdly, for those of you who expressed disappointment at the lack of presentation handouts, please read the next note!

- The GAME website, under the indefatigable leadership of GAME founder, Lew Miller, and with the

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GAME President's Corner

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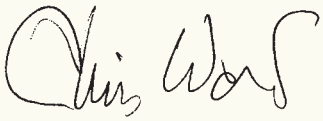
technical assistance of IC Axon, has been reborn in a new and improved, member-friendly format. By way of example, in the members' zone you will now find PowerPoint copies of nearly all the presentations at the June annual meeting. Please visit the site when you have a moment and be sure to bookmark it (www.game-cme.org). The members' zone, along with GAME News, are important benefits of membership in GAME.

- Now is the time to mark next year's annual meeting date in your calendar: June 23–25 in beautiful and historic Montréal. The program promises to be our most stimulating and wide ranging ever and this is an ideal part of the world to tack on a vacation stay.

- Lastly, GAME can only be effective to the extent that we are serving your interests and needs. Please keep feeding us your ideas and suggestions. Better yet, let me know if you would like to get involved on one of the GAME committees.

Sincerely,



Christopher West
cwest@pegasus.ca

Keynote Speaker

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the U.S. catches cold, the whole world of medical education gets sick."

Pharmaceutical companies are stepping up their no-holds-barred marketing tactics because they are under increasing pressure, Cearnal explained. In the past 20 years, the cost of bringing new drugs to market has increased 10-fold, while the length of time it takes has decreased by two-thirds. While in the past, it might take ten years for competing drugs to hit the marketplace, now companies only have six months to two years of exclusivity. Pharma companies must achieve a return on investment (ROI) for education before the competition takes the money away.

On a positive note, those economic trends translate into great opportunities for CME providers worldwide, because well-designed education is the most cost-effective way to improve behavior, said Cearnal. He cited the results of a recent study conducted by Scott Neslin, Ph.D., for the Association of Medical Publications, that demonstrates the value of education. "ROI Analysis of Pharmaceutical Promotion" compared four different types of promotion– detailing, DTC (direct-to-consumer) advertising, journal ads, and physician meetings and events (PME). Physician meetings scored the second highest—with an ROI (calculated as the increase in revenue per dollar spent) of $3.56. Journal ads did the best, with an ROI of $5.00; detailing followed PME with a ROI of $1.72; DTC came in last with a ROI of only $0.19. (For more details on the full study, visit www.amponline.org. Future studies will be conducted on this critical issue.

"Education is an extremely powerful way to gain physicians' acceptance [of therapies]," Cearnal concluded. And the role of education is becoming even more important as products and therapies become more complex.

But education will only succeed, Cearnal said, if CME providers take a strong ethical stance. "We have runaway [healthcare] costs, disenchanted doctors, a dysfunctional healthcare system. The market is starting to sneeze." He pressed attendees to document outcomes of CME in order to quiet media and government concerns. And then he threw down the gauntlet: "Healthcare has become a global political football. Education companies worldwide must agree to the same guidelines for balanced content and scientific integrity, and must rigidly uphold those standards."

GAME members can receive automatic, free subscriptions to Medical Meetings *magazine, can find CME news and trends posted daily in the Capsules section of* Medical Meetings *online at www.meetingsnet.com, and can publicize their educational events by posting them at no charge on* Medical Meeting's Meeting Finder, *also at www.meetingsnet.com.*

Beyond Borders: East Meets West... North Meets South

Picking up on the theme of the keynote address, the moderator of the Beyond Borders session, Professor Niall O'Higgins, Chairman, Department of Surgery, University College Dublin/ St. Vincent's University Hospital, reiterated that the purpose of CME is to improve patient care, and cautioned that "anything that deviates [from that purpose] is a travesty." He talked about how important it is to maintain a distinction between promotion and education, and agreed with Cearnal that CME providers needed to define ground rules. He also expressed concern that the medical profession was not identifying physicians who were "dangerously underperforming."

Focus on Australasia

Presenter:
Neil Paget, Director of Education, Royal Australasian College of Physicians, Sydney, Australia

Martin E. Cearnal's keynote address points were right on target for Australasia (New Zealand and Australia), where "the medical profession is charged by the politicians and public to put its house in order," reported Paget. The profession is shifting its emphasis from qualification to practice to competence to practice, but "CME is as far away as you can get from assessment of competence," Paget acknowledged.

The CME industry is growing in his part of the world, Paget said. CME became mandatory in Australia in 2000; it has been required in New Zealand since 1995. Interest in CME is also growing in Asia and the Pacific, where more than one-half of the world's population lives, Paget said. His college has held programs and has assisted with the development of programs in Hong Kong, Malaysia, Vietnam, Singapore, South Africa, Pakistan, and Papua/New Guinea. Paget noted that that the World Health Organization (WHO) is very interested in CME. Last year, he served as consultant to WHO, setting up a Maintenance of Professional Standards (MOPS) program in Kuwait, which may become a model for other Arabian Gulf countries. The potential for CME opportunities is also strong in India, China, Pakistan, Bangladesh, Indonesia, and sub-Saharan African, he said.

But CME faces challenges in those areas, he said. CME providers must pay attention to cultural diversity and be cautious about "trying to transplant systems from one country to another," Paget advised, adding that providers should focus on the context of activities when exporting them, not just language and cultural differences.

Focus on Canada

Presenter:
Linda Snell, MD, Director of Research and Development in CME, McGill University, Montréal, Québec, Canada

In Canada, where CME is mandatory, education is not limited to clinical topics, but includes management, research, and other issues, said Dr. Snell. The trend is toward self-directed learning, and practice-based CME. Another interesting point: members of the target audience must be involved in the planning process for CME. Interdisciplinary continuing health education (CHE) also is important, she said, for issues such as palliative care, communication skills, patient education, and spirituality.

Because of its size, Canada has developed expertise in distance education, computer-assisted instruction, and videoconferencing. Another strength is the research programs conducted in universities.

In Canada, CHE units in pharma companies are freestanding, and don't report to sales or marketing, said Dr. Snell. As for educating pharma—a recurrent theme throughout the conference—Canada is taking action. A conglomeration of pharma companies has decided that all drug reps should have backgrounds in CHE, and are developing a mandatory course for them. On the downside, all the recent pharma company mergers mean there are fewer companies to approach for support, Dr. Snell said.

Focus on Japan

Presenter:
Toshiaki Shichino, President & CEO, Synergy International, Inc., Tokyo, Japan

In Japan, as in other countries, there is public criticism of the medical system and an increasing demand for quality care. Every day, medical malpractice cases are reported in the media, Shichino said, and the public is pressuring for disclosure of physician records. Once a physician is licensed, there is no further official monitoring of his or her career—physicians can only lose their license if they commit a criminal or illegal act.

While CME is currently voluntary, public interest may change that, predicted Shichino. Possibly impeding the successful growth of CME are the conflicts between the Japanese Medical Association and various specialty societies that produce CME; however, there is a proposal pending that would delineate their roles. The JMA would handle basic learning, while the societies would teach clinical skills. Evidence-based medicine and e-learning are current CME trends, he also noted.

Focus on Europe

Presenter:
Cees Leibbrandt, MD, Secretary-General, European Union of Medical Specialists, Brussels, Belgium

CME is not mandatory in European Union countries at this point, but mandates are being developed, Dr. Leibbrandt

said. He stressed that while the European Accreditation Council for CME's credit reciprocity system was developed to facilitate doctors' travel across Europe to obtain CME, the EACCME is only an umbrella organization. The real power lies in the national authorities that govern CME. And those authorities want to retain their control. Despite the move toward mandatory CME, doctors currently are not under strong pressure to obtain CME, he said. As for the European credit reciprocity system: "We have not been overwhelmed with thousands of requests," Dr. Leibbrandt observed dryly. "But we will be ready when doctors feel they need it."

(For updates on the European CME situation, please visit www.uems.be.)

Focus on the United Kingdom

Presenter:
Howard Young, MD, Vice Dean, School of Postgraduate Medical Education, University of Wales College of Medicine, Cardiff, Wales

As in most of the world, CME is currently voluntary in the United Kingdom but changes are underway, said Dr. Young. Most of the Royal Colleges already require CME and the U.K. is rolling out an appraisal system whereby physicians will have to take a revalidation exam every five years, with CME being an important component.

But mandating a certain number of credits is not enough, Dr. Young said. "Cognate points do not imply cognition." He also pointed out that the cognate points system does not allow for physicians' different learning styles. There are other roadblocks, said Dr. Young. Colleges can be both accreditors and providers—creating conflicts of interest. There are a limited number of secondary care doctors, and their heavy practice schedules coupled with restricted budgets for meetings and travel, means it's a challenge for them to attend CME programs while delivering quality care to their patients. Only doctors in private practice are entitled to tax relief for conference travel. Looking to the future of CME in the U.K., Young asks CME leaders to consider these two questions: "Where is the money going to come from? What about doctors who don't want to participate?"

Focus on South America

Presenter:
Gonzalo López, MD, Director, Educacion Medica Continua Ltda., Santafe de Bogota, Colombia

Neil Paget, Royal Australasian College of Physicians, presents during the Beyond Borders: East Meets West … North Meets South session, while (from left) session moderator Prof. Niall O'Higgins, University College Dublin/St. Vincent's University Hospital, and fellow panelists Dr. Gonzalo López, Greg Paulos, American Medical Association, and Dr. Cees Leibbrandt, European Union of Medical Specialists, look on.

In Colombia, as in many other countries, pharmaceutical companies need to have a greater understanding of what CME is, explained Dr. Lopez. Educators are working to improve pharma's knowledge of CME. "The Standards for Commercial Support are a big issue in South America. We are working with [pharmaceutical companies] and we have developed an [educational] presentation for marketing managers." A new association, the Colombian Association of Pharmaceutical Marketing, has been formed.

A need for greater understanding about CME isn't the only obstacle to obtaining commercial support: GPs prescribe generics, so pharmaceutical companies are more interested in funding specialist education. Nevertheless, there are business opportunities for CME providers to market American content.

Focus on the United States

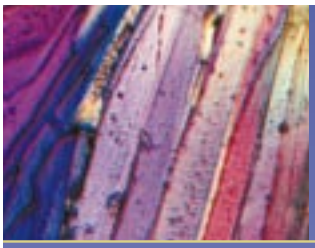
Presenter:
Gregory Paulos, Associate Director, Continuing Physicians Professional Development, and Director, CME Strategic Business Development, American Medical Association, Chicago, U.S.

Currently mandatory in 38 states and required by various specialty societies and hospital boards, CME is a healthy, growing industry in the U.S., reported Paulos. According to the Accreditation Council for CME's 2000 Annual Report, ACCME's 680 member providers brought in $1.2 billion in income, and conducted 49,451 activities.(For the complete report, please visit www.accme.org.)

The AMA is expanding its CME enterprise internationally, with enterprises such as HealthAnswers Asia, a wireless community that reaches 5,000 physicians in Singapore.

To build demand for CME worldwide, Paulos advised making CME mandatory for relicensure, and hitting doctors in the pocketbook—that is, making CME a requirement for attaining hospital privileges, board certification, and other income-related credentials.

(For more information, please visit www.ama-assn.org.) ■



GAME Meeting Report

Beyond Outcomes: Does Return on CME Investment Depend on Your Point of View?

During this session, panelists explained how outcomes and return on investment (ROI) are measured by the different facets of the CME industry in their countries. Assessing outcomes from CME in terms of physician competence and patient care is very difficult, said Helios Pardell, MD, PhD, Executive Secretary, Catalan Council on CME, and President of the Commission for Accreditation of the Catalan Medical Association.

Complicating outcomes assessment is that different players have different outcomes in mind. Third party payers, such as private insurance companies, are interested in cost-effectiveness; physician organizations are interested in recertification and adequate physician performance; and physicians are interested in the usefulness and quality of CME.

Hot topics in Spain are disclosure issues related to commercial support. Such disclosure is not a tradition in Spain, Dr. Pardell emphasized. In the near future, CME in Spain will become more physician-centered, with an emphasis on individual learning styles, he said. And the CME system is expanding: Two weeks before the conference, Spain started a nationwide accreditation system for nonphysician health care professionals, Dr. Pardell announced.

In the United Kingdom, where medicine is run by the government, the aim of CME is quality prescribing, or in other words, "prescribing the right drug to the right patient at the right time for the right condition in the right dose," said John J. Ferguson, MD, Medical Director, Prescription Pricing Authority, National Health Service. “My aim and industry's aims should be the same.” Since there are no formularies, primary care doctors can prescribe whatever drugs they choose, although a small number are blacklisted. (Secondary care doctors do have restrictions on prescribing.)

There is a tension, however, between the government, which is the ultimate payor, and CME providers. For CME to be effective, doctors should learn what their peers are prescribing and what is regarded as best practices—which is not necessarily prescribing the cheapest drug, he pointed out.

The National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement monitor physician behavior. (Pharmaceutical companies have dubbed it 'Nasty,' quipped Ferguson, since industry is concerned it will reduce physicians' prescribing freedom.) The problem, said Dr. Ferguson, is that the system is a top-down approach.

“Information is the most powerful form of promotion,” said Marshall Paul, Chairman, PERQ/HCI Research, Princeton, N.J., U.S., echoing Martin E. Cearnal's keynote theme. The biggest challenge for pharmaceutical companies is understanding their objectives in advance and integrating CME into other forms of promotion.

FDA regulations have made drug promotion more credible. You don't want to foul up CME with promotion, Paul warned. That said, he added, “the outcome from CME can be increased sales.”

Along with other panelists, Paul questioned how long physicians retain the information from one CME event. It's important to followup, to leverage events by reminding physicians of the link between a product and the educational event. A series of direct mail pieces, for instance, can extend the life of the event and improve ROI, he said.

Along the same lines, Alexander Szucs, Manager, Corporate Planning, Knoll/Abbott Pharma, Markham, Ontario, Canada, expressed his frustration with lectures and said that effective education involves the immediate application of learning, and should be reinforced over time.

Reinforcing Paul's statements, Dave Davis, MD, Associate Dean, Continuing Education, Faculty of Medicine, University of Toronto, Ontario, Canada, said that defining objectives is crucial to measuring outcomes. If your objective is to change prescribing habits, then you need to collect data. Partnerships can help achieve your goals. For example, a medical school-based CME provider might have not have access to prescribing data, but the ministry of health does.

Dr. Davis also agreed with Paul and Szucs that a one-shot CME event is not enough. For CME to be effective, you need to:

- Predispose physicians to the information via a mailer or a detailing visit;
- Enable them to change their behavior through a reminder on the wall or a patient education chart; and
- Reinforce the education through a dinner meeting or followup mailer. ■

Beyond Distance: How Tech is Shrinking and Expanding the CME World

Online CME is still a nascent industry, said moderator Mark Evans, PhD, Director, Healthcare Education, American Medical Association, with e-CME activities accounting for only 4% of total CME activities in the U.S., according to the Accreditation Council for Continuing Medical Education's 2000 Annual Report. But Dr. Evans and the other panelists here at a session during the Sixth Annual Game Meeting agreed that e-CME is a growing field, offering both opportunities and obstacles for providers—especially in the international arena.

Approximately one-half of Medscape's members are from outside the U.S., said Bill Silberg, Vice President and Executive Editor, Medscape.com. "International opportunities are more exciting than [those] in the U.S." They can also be more challenging. Just as in other global ventures, CME providers should understand the local health care system, pharmaceutical company/physician relationships, and cultural differences. In addition, to succeed with online CME, vendors need to do their research.

- **Tech Preferences.** Find out how local markets use technology. For instance, CDs are very popular in Japan.
- **Tech Infrastructure.** There is a huge digital divide, Silberg said. "There are countries where you can barely get aspirin. They don't have a clue what we're talking about."
- **Physicians' Access.** In some countries, landline Internet access is expensive, while wireless is more competitive.
- **e-CME Rules.** Make sure you are apprised of the legal, regulatory, and ethical issues regarding e-CME.
- **Physician Relations to Government.** Understand doctors' concerns regarding privacy and security. "Some governments are less trusted by physicians than others," Silberg said.

Another crucial ingredient for success is designing user-friendly learning formats and incorporating adult learning principles, panelists said. I.C. Axon used a problem-based approach when designing online CME, explained Jean Lalonde, President, Co-founder, and CEO of the Montreal-based health education company. At www.mypatient.com, a joint venture with the University of Virginia School of Medicine, doctors enter a virtual waiting room, make up their own cases, and map out treatment plans, emulating their personal practice. Case studies are scaleable, so doctors can download a palm version into their handheld computers. Physicians are not the only market, Lalonde pointed out. I.C. Axon is also targeting physician assistants.

medsn, an e-learning company based in Culver City, California, engages physicians' emotions by using video clips of patients, said Vikas Bhusan, MD, CEO. In the video clips, physicians can see the patient's physical symptoms, and patients and their family members discuss the invisible symptoms—behavioral changes their diseases have wrought. For instance, a patient with hyperthyroidism talked about wanting to kill. 'Before' and 'after' videos show the effect of treatment. Viewing these poignant clips is a powerful way to teach doctors how to diagnose disease and to show them characteristics of diseases they might not normally see. medsn is developing a worldwide video library by giving digital video cameras to doctors to film their patients. "We wanted to bring the patient encounter into CME," said Dr. Bhusan.

"As usual, I come at the end," joked Howard Young, MD, who is a coloproctologist in addition to being Vice Dean, School of

Presenters in the Beyond Distance: How Technology is Both Shrinking and Expanding the CME World session: (from left) Bill Silberg, Medscape.com, Jean Lalonde, I.C. Axon, Dr. Howard Young, Vice Dean, School of Postgraduate Medical Education, University of Wales College of Medicine, Cardiff, Wales, and Dr. Vikas Bhushan, meds

Postgraduate Medical Education at the University of Wales College of Medicine in Cardiff, Wales. As co-founder of EuroTransMed, Dr. Young has had more than ten years experience providing CME via satellite and the Web to hospitals throughout Europe. He summed up the continuing challenges to the growth of global CME, including online education.

- **No Universal Language.** English is not the first language of the majority of European physicians, he said. "People say they understand English, but they don't. The cost of simultaneous translation at conferences is prohibitive." However, he has discovered that physicians will use CME materials to teach themselves English.
- **Different Doctor Populations.** Primary care is not developed in some countries.
- **Extralegal Education.** With web CME, physicians have access to information about drugs or uses not licensed in their own countries.
- **Limited Connectivity.** Some countries in central Europe only have two phone lines out of the country. When beaming interactive satellite broadcasts, e-mail is the only way participants can interact, not via phone or fax.
- **Seven Minute-Module.** Most people only stay on a site for seven minutes. "How do we package CME for seven minutes?" he asked.

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Save this Date!

June 23-25, 2002

Seventh Annual
GAME Conference
McGill University, Montréal

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- **Seven Minute-Module.** Most people only stay on a site for seven minutes. "How do we package CME for seven minutes?" he asked.
- **Competition.** "There are a plethora of Web activities [for physicians to choose from.] There are more health care sites than sex industry sites," he said.
- **Multinational Funding Packages.** With all the pharma company consolidation, budgets are reduced. CME providers need to go to multiple countries to put together funding packages–but if one country doesn't buy in, the whole project can fail. But charging doctors may not work, either, since they are used to getting their CME free of charge. ■

Word of Mouth

Heard at the Sixth Annual GAME Meeting

"The success of your international CME ventures is directly proportional to the number of foreign e-mail addresses in your address book."

Lewis Miller

"When pharmaceutical companies spend money on CME, they are not spending their money. They are spending patients' money. Pharmaceutical companies' profit is made from patients."

Cees Leibbrandt, MD

"A 20-page set of printed practice guidelines makes a nice doorstop. [That's how it will be used, unless guidelines] are reinforced by peer groups, in local small-group learning sessions, and patient questionnaires."

Dave Davis, MD

"You need a partner who you trust to tell the truth. We live and die by these partnerships."

Bill Silberg

"CME does not equate with a doctor's competence. In doing CME, you don't use critical appraisal skills or deal with the changing health care environment. If doctors [don't learn those skills], they will fail; and CME providers will be blamed."

Howard Young, MD

GAME NEWS

THE OFFICIAL NEWS ORGAN OF THE GLOBAL ALLIANCE FOR MEDICAL EDUCATION

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