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2000 GAME Meeting

One or a kind international forum on global trends. The fifth annual GAME conference (to be held in New York City on June 25- 27, 2000) will explore "Changes in CME Around the World." The two-day meet-ing will provide in-depth discussions and presentations on how organizations can benefit from learning more about world-wide trends in continuing medical education (CME). "Formal structures for accrediting CME are expanding rapidly in Europe and Latin America," says GAME president Lewis A. Miller. "This will have a dra-matic impact on medical schools, medical societies, communication companies, and representatives of the pharmaceutical industry. Our upcoming conference is one way to keep up and make contacts with key people internationally." The meeting's keynote address, "Where in the World is CME: Funding, Technol-ogy and Trends", will be given by Richard K. Goodstein, MD, vice-president of Scientific Relations, Bayer Corporation.continue on page 4

Foundation father Receives ACME Award.

Lewis A. Miller, chairman of Intermedica, Inc. and GAME president, received the Distinguished Service Award from the Alliance for Continuing Medical Education (ACME) at its recent 25 th Anniversary Conference in New Orleans. Melvin Freeman MD, ACME president, presented the award "in recognition and appreciation of Lew Miller as a founding father and lifelong member of the Alliance, and for his passion for and motivation to transcend the continental boundaries of North America to foster the internationalization of CME."

Melvin Freeman, ACME president, left, and Lewis A. Miller, GAME president

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Global Alliance for Medical Education

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NEWS FROM AROUND THE WORLD October 2000

Mexico's First GAME Member Celebrates 30th Anniversary

Ing. Pedro Vera Cervera, a founding member of the Global Alliance for Medical Education, announces that this month his company, Intersistemas, SA de CV, of Mexico City, celebrates its 30th anniversary. Intersistemas is the leading publisher of continuing medical education programs in the Spanish language, including programs developed with the leading specialty societies in Mexico and translations of major CME programs from U.S. specialty societies.

At the anniversary party on October 5, many other GAME members were in attendance, including Lew Miller, founder of Intersistemas in 1970 and immediate past president of GAME; Chris West, GAME vice-president; Gonzalo López, GAME secretary, and Dennis Wentz, past board member.

Special awards were presented to Mexican specialty society representatives related to their development of CME programs over the past years.

5th Annual GAME Conference Makes Headline News

The July/August issue of Medical Meetings magazine highlighted its FYI "hot" news section with an article reporting the historic Europe-U.S. CME credit exchange announced at GAME's 5th annual conference in New York last June.

The report described the two-year agreement between the American Medical Association and the European Accreditation Council for CME, covering live events only. Tamar Hosansky, editor of MM, wrote:

"But there are major differences between European and American medical meetings - the most striking being in the area of industry/provider relations. In Europe, for instance, pharmaceutical companies are free to pay physicians to attend conferences - a practice that violates AMA and Accreditation Council for CME guidelines. Will conferences operating under the European system still be eligible for U.S. credit?"

She quotes Dennis Wentz, MD, director of AMA's division of continuing professional development: "We had to gulp and swallow. A code of ethics is up to [each] country. We can't impose an American code of ethics. We're not completely clean here. Forty percent of attendees [at some conferences in the U.S.] are international and [pharmaceutical companies] have paid their way."

Europeans attending CME conferences in the U.S. will have to check with their own national authorities to receive credit, Hosansky wrote, and added this note from Leonard Harvey, MD, UEMS external liaison officer: "We have been highly criticized for even going this far. Some countries don't even speak to each other."

The cover of the July/August issue of MM featured another GAME player: its treasurer, Frederic S. Wilson, director of professional relations at Procter & Gamble pharmaceuticals. In the accompanying article, he answers questions on how CME providers can go about getting commercial support from the pharmaceutical industry. A quick summary of his responses in the magazine follows:

Go local if you're looking for less than $10,000, otherwise to the home office.

Medical societies will do better having a primary contact in their organization and in the company organization.

Prioritize your needs - and remember timing is important in approaching a company. Funding may be more available in the company's last fiscal quarter.

Companies can offer support beyond funding in terms of resources and recommendations - all within ACCME guidelines.

It's OK to use prescribing data to measure effectiveness, as long as its use is protected.

Enduring materials based on a live meeting can reach the majority who can't attend, and their use lowers the cost per physician. Enduring materials still have more appeal than the Internet.

Sometimes communications companies are a little easier to work with than academic CME providers - more respectful of bottom-line mentality.

U.S. CME Program Gets Accredited in the U.K.

Dr. John Harris, president of Medical Directions, Inc., of Tucson AZ, has announced that the company's CME online program, Melanoma Education for Primary Care, has received approval from the Post Graduate Education Authority of the Royal College opf General Practitioners to offer 18 hours of approved credit.

"We believe this is the first example of a U.S.-developed Internet CME program being approved for physicians in Europe," says Dr. Harris. The program is available to physicians worldwide through the Virtual Lecture Hall (www.vlh.com) and to British physicians for credit through www.ukpractice.net.

Where is E-Health Going in Europe?

Europe is poised to be the next major player, after the U.S., in the field of Internet healthcare, writes Dan Twibell, president of NGDA Interactive Communications, Columbus, Ohio, in the August issue of Pharmaceutical Executive.

Twibell says that Internet use in Europe trails the U.S. by 18-24 months because of lack of a common language, lack of a common currency and high-priced consumer Internet access. Other problems include conflicts between European Union directives in e-commerce and those of member states, as well as a ban on direct-to-consumer advertising.

Nevertheless, Twibell suggests, there are great opportunities for consumer health education and prescription drug sales on the Internet in Europe. Internet penetration rates across Europe in 1999 were from 68% in Sweden to 6% in Spain and Portugal, averaging 24%. The growth rate averages 200%! The prevailing view, says Twibell "is that the EU will soon adopt a DTC advertising model similar to the U.S. one. Proponents believe it's futile to ban this form of communication when EU consumers can easily access U.S.-based web sites."

He mentions the following key players in European e-pharmacy operations:
Pharmacy2u.co.uk
Allures.com, partnering with NetDoctor.co.uk
Pharmaworld.com

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About GAME

The Global Alliance for Medical Education (GAME) was established in June 1995 to serve as a forum for the exchange of ideas among nonprofit and for-profit organizations involved internationally in the development and marketing of CME and health education programs. The original name, International Alliance for Health Education, was changed in 1998 because of possible confusion with another organization (International Association of Healthcare Educators).

Our Objectives

By participating in GAME meetings and programs, you will be able to achieve the following membership objectives:

- To share market experiences in the continuing globalization of physician and consumer health education.
- To meet new potential partners in educational and/or business development.
- To learn from experts about new trends and how they may affect you.

GAME Membership

Membership in GAME will pay for itself through increased knowledge and skills, as well as through opportunities to be more effective as a developer, marketer, or purchaser of CME and health education.

As a member you have access to several key benefits:

- Reduced fee for the annual meeting
- Copies of available presentations from the annual meeting
- Access to the Internet World Wide Web site for discussion groups.
- Opportunity for interchange with other members
- Regular newsletter
- Exchange of information on trends in CME and health education around the world.

A GAME membership application is available on-line (link to application). Print out the application and mail it together with memebership dues. You can benefit from substantially reduced rates by including additional members from your organization.

Download Membership Application (PDF format, Acrobat Reader required)

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Global Update

Highlights from the Biennial Meeting of the European Academy for Medical Training by Lewis A. Miller

United Kingdom

"We're changing the name of CME to the broader concept of CPD-continuing professional development," says Dr. Adrian Marston of the Royal College of Medicine. The new concept has been adopted by all the Royal Colleges (independent bodies supported by their members, not the government). Each college has a director of CPD, all of which belong to a new organization known as DOCPD. At the moment, the system is still credit-hour based. Each doctor needs 250 credits over 5 years, including external sources such as conferences, lectures and distance learn-ing; internal sources such as journal clubs and small groups meeting in hospital; and reading, at least 2 hours per week but a maximum of 5 credits per year. Providers must get prior approval from a Royal College for a CPD activity, which is then mutually recognized by all other colleges. According to Professor Janet Grant of the Joint Centre for Education Medicine, a major developer of the CPD concept, the system incorporates: o needs assessment-a personal appraisal coupled with review by local colleagues o personal development plan-outlining what to do and why o learning and recording-the activities and record fulfilling the plan o evaluation-leading to revalidation through local profiling of performance. The Royal College of General Practitioners is establishing a program of accredited professional development along the lines described above. Britain's system is not mandatory, but is heading in that direction. The General Medical Council, the country's licensing body, has recently required recertification after 5 years, though the methodology has not been completely worked out. Nor has the question of who will pay - the doctor, the National Health Service (NHS) or pri-vate insurers, or a combination. The NHS, meanwhile, is pressing ahead to educate general practitioners about prescribing habits and costs. .

France

Prof. Bernard Glorion, who had chaired France's National Council on CME, reports that the proposed mandatory CME system is in a state of "instability and uncertainty". The previous minister of health, who pushed through the legislation on the basis that mandatory CME would cut health care costs, has been replaced. It appears that new legislation is in the works, recognizing that (a) CME should be voluntary, (b) its end point should be quali-ty of care, not costs, and (c) there is a need to evaluate doctors throughout their careers. As a result, says Professor Glorion, two new groups have been set up: the National Agency for Health Recertification and Accreditation and the National Union of CME. What will the new CME look like in France? Here are the elements of the program, described by Dr. Pierre Haehnel, secretary general of the Conseil National: o training and validation of a doctor's skills based on a system similar to the UK's national vocational qualifications, in which knowledge and skills are defined by level of work and must be tested from time to time o defining competence as the capacity to deal with a new situation, integrating knowledge and personal effectiveness to be proven over the doctor's professional lifetime o development of a matrix, specific to each specialty, outlining objectives, roles, elements of competence, criteria of performance, knowledge needed, and proofs required. Dr. Haehnel added that, while current legis-lation promotes voluntary compliance, it will probably move to the obligatory.

Germany

Dr. H. Eckel reported that Germany has accepted the idea of a CME certificate, based on 150 units over three years, and issued by state medical associations. Extra points would be allowed for participation in evaluation activities and quality groups. The state medical associations, starting with Bavaria and Thuringen, plus some specialty societies, have established ways to validate the CME experience; seven already have certification programs, three will be starting very soon. "We don't want statutory, compulsive meas-ures," Dr. Eckel said. "CME must be genuinely voluntary. Personally, I prefer monetary rewards to sanctions. We must find ways to evaluate effectiveness of CME, and to determine what is a competent doc-tor." He concluded by encouraging EAMT to work on these issues, and to develop guidelines for the future of CME in Europe. Switzerland The CME requirement in Switzerland is 80 hours a year, 50 in the

doctor's own specialty and 30 in literature. Dr. Ralph Bloch, a leader in Swiss CME and member of the Alliance for CME, said that voluntary CME has worked well, although a 1998 law stipu-lated that the Ministry of Health had the right to introduce recertification and make CME compulsory. The FMH, or physicians' guild, is implementing the process, permit-ting each specialty society to set its own rules, and each cantonal society to set the rules for GPs (a total of 80 bodies!). This will be in place by the Year 2000 and all CME programs will be available on the Internet.

Belgium

"In Belgium," says Dr. Jean-Pierre Joset, of the Belgian Federation of Medical Societies, "we don't talk about recertification; we talk about accreditation." An accredited doctor receives a bonus of 500 Euros (over $500) as a lump sum, whether specialist or GP. Each doctor needs 200 units per year. There are three elements: o what the doctor thinks is useful for his/her practice o 30 units in ethics and economics, required by the insurance industry o 40-80 units in local medical evaluation groups. Accreditation also involves a certain level of activity on an ongoing basis, a minimum of half a day a week, and must be renewed every three years, Dr. Joset adds. Of the 18,000 GPs in Belgium, 75% are accredited; of the 21,000 specialists, 72% are accredited. To monitor quality of care, no examinations are required; instead, local evaluation groups monitor profiles of prescriptions and con-sumption of diagnostic services. Each doctor can select a local group in which to partici-pate. There are 600-plus GP groups, 840 specialty groups, each of which reports to a regional commission, which then reports up to national bodies. The use of local groups, according to Dr. Joset, has resulted in higher attendance at CME activity, reduced obsolete practices and use of drugs, lowered costs to society, and improved interaction among peers.

Austria

Dr. Wolfgang Routil, vice-president of the Austrian Medical Association, reports that CME is compulsory, but that proof is on a voluntary basis. Quality is provided by a diploma in CME. Sixty percent of providers are accredited, but the number of applicants is low, he said. So far, only 7.2% of GPs and 5.3% of specialists have demonstrated that they have met the requirement of 100 hours of CME in 3 years, which will soon go to 150 hours. "There aren't enough accredited providers," Dr. Routil said.

Norway

When GPs obtained specialty status in Norway in 1985, it became the first specialty to have recertification, including CME courses, reports Dr. Hans Asbjorn Holm, deputy secretary general of the Norwegian Medical Association and member of the Alliance. Specialty status provides 20% high-er earnings, but lack thereof does not disqualify a doctor from practice. Subsequently, rules were changed to move CME from didactic courses and include practice visits, small group activities, working in hospitals, teaching and research. In September 1999, the Norwegian Medical Association adopted a policy document based on these key points: o A doctor's desire to be more competent is the most important motivating factor for continuous learning and change. o Professional development is a legal and ethical obligation. o Recertification as such is not the cure, and hardly the prevention, of substandard practice. o Any system of recertification must be flexible. o A way forward to formal requirements could be a credit point system capturing a broad range of learning activities. Documentation may be linked to plan-ning and evaluation of these activities. o Legal consequences of mandatory recertifi-cation need clarification before becoming a requirement. o Resources must become available for CME/CPD and the costs acknowledged as an integral part of health care.

Catalonia/Spain

With assistance from Helios Pardell Executive Director, Catalan Council on CME In 1989, the Catalan Council on CME was created, assembling the most relevant part-ners in the CME field, namely the Catalan Ministry of Health, the Catalan Ministry of Education (Universities), the Catalan Academy of Medical Sciences and the Catalan Council of the Colleges of Physicians. In 1997, a CME accreditation system was implemented. It is expected that the College of Physicians of Barcelona will implement the first Spanish recertification initiative for physicians, by the year 2000. Concerning Spain, the Spanish Council on Continuing Education of Health Professionals was created in 1998, under the leadership of the Spanish Ministry of Health. The 17 autonomous regions are represented in it, as well as the Spanish Council of the Colleges of Physicians, the Spanish Federation of Medical Societies, the Spanish Council of Medical Specialties and the Spanish Council of the Universities. The Spanish system of CME accreditation was implemented in 1999, in close connection with the Catalan Council on CME accredi-tation system. Currently, the essentials of the

procedure for CME providers recognition are in preparation. Recertification is not manda-tory for Spanish physicians.

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Trend Lines

Dr. Michael Fordis
Baylor College of Medicine

Trend Lines Online CME On Its Way while no central data have been collected on the amount of CME online, one look at the Internet tells the story. There are literally hundreds of sites already offering CME and more are on the way as the private sector enters the online arena in droves.

A wide range of methodologies, approaches and technologies are now available-from simple cases and text-based materials to full-range multimedia offerings including audio and video con-ferencing, and even interactivity.

What's more, CME professionals are opti-mistic about its potential. A survey con-ducted by I.C. Axon at the 1999 Alliance for Continuing Medical Education Conference found that 87% of these professionals agreed the Internet would be an excellent medium for CME.

The other important part of the equation is, of course, the end user. Are physicians taking the majority of their CME online? "Not yet," says Jim Hughes, director of Education and Internet Services at Dowden Publishing. "They're doing a lot of literature searches and using email, but, in my opinion, online learning represents a low percentage of their current use."

Tom Sullivan, president of Rockpointe Broadcasting, agrees. "Online learning is not widely used," he says. "Mainly because there is a paucity of good materi-al. For many physicians, online experi-ences haven't been optimal. There's a common perception that if you throw up it up on the web, physicians will use it. That's just not the case. Physicians want to see quality."

Quality is a key issue for online CME and, presently, there is a large degree of variability. "It's a challenge for providers to use the technology well," says Michael Fordis, MD, associate dean and director, Continuing Medical Education and director, Center for Collaborative and Interactive Technologies, Baylor College of Medicine. "An online presentation that does not use the technology well or is not compelling likely will not be used by physicians." he says. "It's easy to do things that don't work well and much harder to do things that do work well and add value."

Providers must also consider the issue of control. Control is possible when produc-ing an enduring material that is fixed in print, but online there is a potential loss of authority over context and appearance. Educational materials disseminated to multiple sites can find themselves juxta-posed inappropriately to advertisements in adjacent frames no longer under the direct control of the CME provider.

Furthermore, physician Internet usage lags behind that of the US adult popula-tion, recently reported to have reached 53%. Only 40-41% of physicians have a computer at their home or office and only 37% use the Internet, according to Fordis. Nevertheless, physicians who are coming online are doing so as newly available equipment significantly increases access speeds (bandwidth). Fordis suggests that these new converts, because of their incomes, might disproportionately acquire cable modems, DSL or ISDN connections offering higher bandwidth connections to the Internet. As a result, they may expect CME providers to meet the challenges of delivering graphically rich, multimedia presentations that they find elsewhere on the Net.

Then there is the issue of peer interaction. "You often hear physicians say that inter-acting with peers is the greatest benefit of attending live CME meetings," says Hughes. "Online learning removes this collegial atmosphere."

The Upsides
For all the disadvantages of online CME, there are many upsides. The tools for creating online CME are fast becoming more robust and simpler to use. This medium allows real-time access to feed-back and providers can monitor how and how often physicians are using an online learning tool.

"The level of interactivity in online CME will continue to increase," suggests Fordis. The CME learning experience will become more active and less passive, hopefully enhancing knowledge acquisition.

For physicians, the Internet offers a potent combination of accessibility and convenience, 24 hours a day, seven days a week. It allows them to be more selective by allowing a quick review of course con-tent. And, down the track, it will create an opportunity for just-in-time educa-tion- the provision of immediate in-clinic tools to answer a physician's queries concerning diagnosis, therapy and other management issues.

Importantly, online technologies will effect healthy change within the conven-tional CME arena. "Online options will not replace or threaten traditional CME, but will complement it," says Fordis. "Traditional meeting approaches will continue to serve an important function with supplementary interactive materials offered online before, during or after a live meeting."

Fordis is convinced that the advent of online learning can only improve and enrich the CME market, particularly with improvements in content, convenience and technology. "It will ultimately force a revolution within CME and help us all to better meet the educational needs of physicians," he concludes.

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Practical Matters

Dr. Dennis Wentz
American Medical Association

How wll does CME travel ?

In many countries of the world, high quality CME is a burgeoning local enterprise. But can it be extended beyond a parochial application.

"Yes," says Dennis Wentz, MD, director of Continuing Physician Professional Development at the American Medical Association (AMA). "It is entirely appropriate to take good CME materials to other countries. Good CME is good CME wherever it appears and is equally needed around the world."

While this process suggests an exporting angle, Wentz says it is imperative to avoid using this term. "It's demeaning and implies that other countries are not capable of producing their own wor-thy materials," he says. "Instead, it should be about sharing quality CME materials, wherever it occurs and whomever attends."
In many cases, this sharing of quality CME is already underway and is a sign of things to come. Yet before this global move gathers pace, basic universal standards that delineate quality CME must be worked out and agreed to, insists Wentz. To a certain extent, standards already exist in many parts of the world, although they need to be "tweaked" and formalized, according to Wentz. Many medical organizations are presently working at the highest level to achieve this.

The European Union of Medical Specialists, for instance, is hard at work developing standards in Europe, with the assistance and input of the AMA.
An important component of setting universal standards is an awareness and acceptance of a country's local conditions-from issues of language and clinical practice to social and cultural val-ues. "We have to be cognizant that other countries must set stan-dards for CME that accommodate their own needs and realities," says Wentz. "There has to be an agreement of overall standards, but with some flexibility built in."

Where do credits come in? The reciprocal granting of CME credits is relatively rare, given that credit systems are relatively uncommon in most countries. In Europe, however, this is fast changing. The Catalan region of Spain, for instance, has recently implemented a newly-created credit system.

As more credit systems are established, the opportunities for recipro-cal granting of credits will likely rise. Until then, CME providers are negotiating, usually on a program-by-program basis, an acceptance of programs for local CME credits in countries where credit systems exist (see sidebar below).

At the same time, other innovative approaches are in development. The AMA is working on an international credit system that may be in place within five years. Greg Paulos, associate director of Continuing Physician Professional Development at the AMA, explains: "The idea is that a CME activity would not only issue a local credit, but also a higher level, international credit that the physician could use in his or her own country. This international credit system would not replace the local currency but would complement it."

How would these international credits be used? According to Paulos, a Mexican physician, for example, might attend a CME activity in his or her own country that issues the local CME credit or points needed to maintain board certification. This same

physician could also attend CME activities in other countries that issue the new global CME credit. The Mexican physician would be allowed to use this global or international credit towards his or her local require-ments. This, of course, would work in reverse for physicians outside of Mexico that are from countries participating in the global credit system.

Recently, Paulos and Wentz traveled to Mexico to discuss this con-cept with key medical groups, including the Mexican Academy of Medicine. Their feedback was extremely positive and plans are mov-ing ahead. "We are hoping to bring Mexico into the loop first and then branch out to other Latin American countries," says Paulos.

"The Mexican interest in moving ahead is significant," adds Wentz. "Under NAFTA (North American Free Trade Agreement), they are seeing positive changes in commerce…so why not in medicine." CME Goes Abroad-A Case Study Lewis A. Miller and Intermedica Inc. recently developed a translated version of the Medical Knowledge Self-Assessment Program of the American College of Physicians (which carries approximately 50 hours of credits in the US) and took it on the road to Mexico. There, they approached the Mexican Board of Internal Medicine about offering credits for this program. After some consideration, the Board agreed to award 60 to 70 credits towards recertification for physicians completing the program.

"This is a concrete example of taking a quality program that was approved for credit in the US, translated and accepted for credit purposes," says Miller.

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GAME Opinion

The ethics of commercial CME

GAME News senior writer Lynda Cranston recently spoke to Timothy Brigham, PhD, assistant dean for Graduate and Continuing Medical Education, Jefferson Medical College, about the controversial issue of accrediting commercial CME firms. A growing number of CME-accredited advertising and marketing firms are providing CME courses for physicians. What is your opinion of this trend and what are its pitfalls and/or benefits? This is a very sensitive topic. I operate within the academic CME sector, but I do work with people in commercial CME organizations who are of high integrity. I believe that commercial groups are playing by the same rules that we are. What's more, the commercial groups I work with are using our faculty; faculty that I can trust to abide by sound ethical standards. The pitfalls of commercial involvement in CME are clear. There is potential for disaster if you can't trust the commercial provider to give unbiased information to the learner. There will be some organiza-tions entering the market with the sole purpose of making money and not because they care about medicine, physi-cians and patients. Furthermore, topics important to practicing physicians that aren't "sexy" nor in the interests of com-panies with good financial resources will not likely be high on the priority list. On the other hand, the private sector can make enormous contributions. For instance, commercial CME companies often have more resources to devote to their educational programs, because they are able to concentrate on and monitor fewer activities, as opposed to the hun-dreds of different CME activities we work on at any one time. We also can't forget about the role of pharmaceutical and device companies in developing new and better therapeutic agents and devices that improve the prac-tice of physicians and the lives of their patients. These companies have the financial resources to help the academic sector continue to provide CME.

What is the key issue raised by the recent resolution authored by 47 medical schools that questioned the accreditation of CME firms?

The major issue that the resolution addresses quite appropriately is "what is the influence of funding?" It raises everyone's awareness of how we think about the relationship between a fund-ing organization who may have pro-prietary interests and CME. But the argument that we should automatically be suspicious of a profit-making organi-zation is specious and misleading. If you look at continuing professional education outside medicine, there are a multitude of commercial providers. Another issue to consider is the finan-cial state of medicine in the US. The economy is booming, except in medi-cine, which is in a recession. In Philadelphia, for instance, a medical school has gone bankrupt. And another medical school-arguably one of the finest schools in the country-had large operating losses in the millions of dollars last year. Funding for medical education, in general, is a big concern. And funding for CME is even bigger. More and more of us in academic med-icine are expected to self-support our programs. We cannot do so without outside funding. In other countries (in Latin America, for instance), where CME is less well developed, financial support-as long as it preserves the integrity of an educational event-is equally or even more vital. Are commercial companies that are closer to the "money" more likely to have biased programs? Perhaps in some cases, although I've seen no data to prove it. The real issue we should then consider is how to help providers ensure objectivity within CME programs.

On a practical basis, how can this be achieved?

By creating practical tools. The Consortium for Academic Continuing Medical Education (CACME) is an alliance of four medical schools in Pennsylvania that comprises Jefferson Medical College, University of Pittsburgh School of Medicine, Penn State University College of Medicine and Temple University School of Medicine. Within

CACME, we have developed a tool that will have national implications for assessing a program's risk of bias. We have developed criteria (such as number of commercial sup-porters and ability of participants to critically evaluate content) that are rated according to risk. By completing a risk stratification in the pre-planning stage, a program can be identified as high or low risk. A high risk activity is not inherently bad, but by identifying it, we can then implement monitoring strategies to prevent bias and protect the learner. This tool could be used by both aca-demic and commercial providers, and we will be encouraging others to adopt it. Right now, we're still refining it and will be assessing its reliability and valid-ity with psychometric testing. .

Is it up to physicians to be informed consumers of CME?

Of course. Physicians not only have to be savvy consumers, but they also have to be cognizant of and abide by profes-sional standards. But it's not just up to physicians. It's going to take synergy among all players. Providers (both academic and commer-cial) have to operate with absolute integrity. So do pharmaceutical and device companies. We all must work together to achieve this synergy and provide sound CME for all physicians. To find out more about CACME's risk stratification tool, contact Dr. Brigham at timothy.brigham@mail.tju.edu.

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Dowden Publishing Company, publishers of Contemporary Surgery, OBG Management, The Journal of Family Practice, Mayo Clinic Proceedings and 20 consumer health newsletters and mini-magazines, has recently launched a new Education Division offering sponsors and funders the opportunity to benefit from the company's strengths in a new, highly focused manner. The Education Division will leverage Dowden's unique position as a medical and health information provider with broad experience in both professional and patient/ consumer communications. For more information, contact Jim Hughes at 201-782-5710 or jhughes@dowdenpub.com.

At the Distributed Medical Intelligence Conference in March, guest speaker and GAME member, Charles Crawford, vice-president of I.C. Axon, presented his vision of the future for Internet-based CME. Citing research done through governmental, professional, academic, media and corporate sources, Crawford concluded that physician demand for online CME and the businesses that provide these services will continue to grow due to improved content, convenience, and evolving technology and delivery systems.

Jefferson Partners, a new concept in international medical education, will shortly be launched to enable hospitals in countries outside North America improve the quality of edu- cation of staff physicians, patient care, research and patient education. Jefferson Partners is a joint venture among Jefferson Medical College, Intermedica Inc. and Lewis A. Miller.

It is expected that most Jefferson Partners will be private hospitals in Latin America, Asia and Southern Europe. Each hospital will be identified as a Jefferson Partner and will receive a negotiated package of services which might include CME and other training on site, via distance learning and through fellowships at Jefferson in Philadelphia.

Negotiations are currently underway for the first Jefferson Partners in Turkey and Mexico. For further information contact Lew Miller, lamiller@inter- medica-inc.com, or associate dean John Monnier of Jefferson, John.Monnier@mail.tju.edu.

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Game Agrees on Outreach Strategy.

GAME Board of Directors gathered at the recent annual meeting of the Alliance for CME in New Orleans. There, they addressed usual board business, from budgetary issues to continuing development of its website and newsletter. A new international initiative was also on the agenda. Board members agreed that there is an opportunity for GAME to take a leading role in sharing CME know-how in Latin America and Europe, areas where there is a growing need for more formalized CME. Two task forces-one for Europe and the other for Latin America-will be formed to develop outreach plans. And, given the global reach of the Internet, the GAME website will be a natural fit for this international strategy. According to Lew Miller, this initiative is still on the drawing board, but will move ahead shortly. Stay tuned.

New Board Members Wanted Interested in serving on the GAME Board of Directors? If so, please submit a brief letter outlining your interest and qualifications to the committee chair: Carroll V. Dowden, President, Dowden Publishing Co., 110 Summit Ave, Montvale NJ 07645.

Upcoming CME Meetings The European Union of Medical Specialists is holding a special informational meeting on the proposed CME accreditation system for Europe in Brussels on May 12, 2000. For further information, contact Dr. Cees Leibbrandt, secretary general at uems@skynet.be. On May 13, 2000, the Alliance for CME (ACME) will convene an international meeting in Brussels to discuss how to proceed in Europe. For more information, contact Bruce Bellande, ACME executive director, at bbellande@acme-assn.org.