A tale of Congress, continuing medical education, and the history of medicine

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Well-intentioned attempts by the Senate Finance Committee to improve the content and quality of continuing medical education (CME) offerings had the unanticipated consequence of decimating academically oriented history of medicine conferences. New guidelines intended to keep CME courses free of commercial bias from the pharmaceutical industry were worded in a fashion that caused CME officials at academic institutions to be reluctant to offer CME credit for history of medicine gatherings. At the 2013 annual conference of the American Association for the History of Medicine, we offered a novel solution for determining CME credit in line with current guidelines. We asked attendees to provide narrative critiques for each presentation for which they desired CME credit. In this essay, we evaluate the efficacy of this approach.

In 1957, Guthrie spoke of the history of medicine as

a means, perhaps the only means, of reuniting a profession now so fragmented by many specialties, a means of reviving the wide outlook of former times. . . . Never before, in the long evolution of medicine, has there been a time when there was greater need for retrospection—for looking back, in order that we may be better qualified to look forward (1, 2).

Physicians and academic historians of the history of medicine meet and discuss their research, but well-intentioned attempts by the Senate Finance Committee to improve the content and quality of continuing medical education (CME) offerings have had the unanticipated consequence of decimating academically oriented history of medicine conferences. This article outlines efforts to allow CME credit at those meetings following the changes in CME guidelines.

CME IN HISTORICAL CONTEXT

The genesis of CME in the United States is largely the result of the efforts of the Mayo brothers, Charles and William. Visiting surgeons, anxious to incorporate novel surgical techniques, traveled to the Mayo Clinic in Rochester, Minnesota, to learn about surgical progress. Eventually these itinerant surgeons created a Surgeons Club, which “partook in vigorous daily discourse regarding new techniques being advanced” (3). In 1927, the Clinical Week, “the prototype of the modern CME course,” began, which evolved into today’s popular clinical reviews at

the Mayo Clinic (3). Other medical schools and eventually specialty societies embraced the CME torch. The American Urological Association initiated the first mandatory CME program in 1934. By 1957, the American Medical Association (AMA) had published the first set of CME guidelines. However, in the 1970s, “the political predominance of the AMA in continuing education was questioned by other professional associations” (4). As a result, in 1981, a successor to the AMA’s Liaison Committee on CME—the Accreditation Council for Continuing Medical Education (ACCME)—was formed.

This council, with guidance from various educational and professional groups, was a step forward in the professionalism and quality of CME. From this vantage point, the rather constitutional-sounding declaration is found: “The ACCME accreditation process is of, by, and for the profession of medicine” (5). Standards to assess accreditation requirements ensued, such as the Seven Essentials in 1982. By 1998, the revised System98 “encouraged accredited providers to focus on CME that linked educational needs with desired results, and to evaluate the effectiveness of their CME activities in meeting those educational needs.” By the early 21st century the ACCME positioned itself “to support US health care quality improvement efforts and to align with emerging continuing professional development systems to support US health care quality improvement efforts” (5).

CME system challenged

This seemingly bucolic and utopian situation for CME and the American medical education system was eventually challenged by the US Congress. In a 2007 letter from Senator Max Baucus, chairman of the Committee on Finance, and ranking committee member Senator Charles Grassley, addressed to Dr. Murray Kopelow, chief executive for the ACCME, the senators noted that “the pharmaceutical industry spends more than a billion dollars a year to fund CME programs that are accredited by the ACCME” (6). The letter harshly criticized the ACCME for poor oversight of CME activities and failure to adequately

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limit bias in big pharmaceutical companies' CME activities and indicated that the ACCME focused on the

documentation surrounding the process for funding and creating CME activities, as opposed to the substance of the activities themselves. For example, it does not appear that ACCME review involves analyzing the contents the educational activities created for accuracy, to determine whether the activities include a fair and balanced discussion of competing therapeutic options, or whether the activities favor products manufactured by the commercial sponsor (6).

By extension, one can see the implications: the integrity of clinical trials, biased and tainted dissemination of knowledge, and the degradation of the very fabric of trust between physician, patient, and society. From this perspective, the notion that the abyss-like pockets of the pharmaceutical industry are funding CME at fine restaurants, ski resorts, and cruises is unsavory to contemplate. More troubling is the conflict of interest that is inevitable in presentations of industry-sponsored research of principal investigators whose research is often also funded by the National Institutes of Health (NIH). Such potential conflicts of interest fueled the skepticism of the Senate Finance Committee about the role and independence of the CME enterprise.

In the spirit of engaging this congressional criticism, the ACCME developed the descriptions and guidelines that appear in the box below (7). Unfortunately, CME offices across the country, faced with increasing scrutiny and threats of probation

Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public.

ACCME Note:

The definition below describes the content that the ACCME considers acceptable for activities developed within an accredited provider's CME program. The ACCME definition of CME is broad, to encompass continuing educational activities that assist physicians in carrying out their professional responsibilities more effectively and efficiently. Examples of topics that are included in the ACCME definition of CME content include:

- Management, for physicians responsible for managing a health care facility
- Educational methodology, for physicians teaching in a medical school
- Practice management, for physicians interested in providing better service to patients
- Coding and reimbursement in a medical practice

When physicians participate in continuing education activities that are not directly related to their professional work, these do not fall within the ACCME definition of CME content. Although they may be worthwhile for physicians, continuing education activities related to a physician's nonprofessional educational needs or interests, such as personal financial planning or appreciation of literature or music, are not considered CME content by the ACCME.

Figure. CME content: definition and examples. Source: ACCME (7).

for inappropriately awarded CME credit, began refusing to offer CME for history of medicine seminars. This contrary action by institutional CME boards continues despite the language outlined by the ACCME, which provides support for the history of medicine as an avenue for legitimate intellectual inquiry and study serving to benefit the practice of medicine.

THE CHALLENGE OF CME FOR MEDICAL HISTORIANS

What are physician historians of medicine to do? Caught in the cross-hairs of a skirmish involving the pharmaceutical industry, well-intended congressional members, and the formal CME enterprise, physician historians of medicine have become victims of unintended collateral damage. What is at stake? Dollar-wise, not much. Money spent on academic history of medicine conferences is a mere pittance compared to the cascade of dollars involved in NIH grants and pharmaceutical funding for drug research and development and drug trials. Most history of medicine conferences receive no pharmaceutical industry funding. Depending on the particular conference, a variable mix of PhD graduate students, history professors, lawyers, librarians, physicians, and a slowly increasing breed, an MD with a PhD in history, attend these gatherings. A drug company representative is hard to find under these circumstances, although rare book dealers often set up shop on the environs.

What is at stake is the long and fruitful intercourse between physicians and historians of medicine, and the resulting benefit to patients and society. Note the opening paragraph of a recent article in the *New England Journal of Medicine*:

Over the past half-century, historians have used episodes of epidemic disease to investigate scientific, social, and cultural change. Underlying this approach is the recognition that disease, and especially responses to epidemics, offers fundamental insights into scientific and medical practices, as well as social and cultural values. As historian Charles Rosenberg wrote, "disease necessarily reflects and lays bare every aspect of the culture in which it occurs" (8).

In the swirling winds of discontent and the increasingly politicized milieu in which medicine is practiced today, the profession of medicine would do well to understand its roots and its role in society and to account for how we have arrived at the current state of affairs. As Harvard historian Peter Bol sagely observed:

How do I know the historian's mind-set when I see it? I know it because it's somebody interested in how things change over time, but not just that. They're also interested in the *problem* of how things change over time. And how to account for change over time (9).

CME AT THE AAHM 2013 ANNUAL MEETING: TOWARD A NEW PARADIGM

Confronted with this disconnect between CME and history of medicine scholarship, a group of scholars, including these authors, hosting the 86th annual meeting of the American Association for the History of Medicine (AAHM) in May 2013 offered a novel solution to the predicament. As it seemed almost

an ethical conflict at worst and difficult at best to declare, seemingly arbitrarily, ahead of time whether a presentation may or may not meet the criteria for awarding CME credit, the authors of this paper shifted that burden to the physician seeking CME credit. We asked the attendee: "Describe how this presentation addressed your current practice-based needs: How will you use the information presented to 1) change/impact how you care for your patients; or 2) improve your medical administrative skills; or 3) enhance your research skills." In other words, credit would be based on physician response.

With open-minded and close collaboration among the host university CME office, the national office of the AAHM, and the ACCME, an agreement was forged to pursue this approach. Through the support and collaboration of the chair of the institution's CME committee, we reached a suitable mechanism for providing CME for physicians attending the AAHM meeting. Members of the local arrangements committee of the host institution also reviewed the process and supported it. While an online submission process for physician attendees seeking CME credit was preferred, time and finances led in this case to a paper submission process. The revised rules of the national ACCME had been the barrier preventing participants in history of medicine meetings from obtaining legitimate credit. Once approved by the national offices of the AAHM and the ACCME, this hurdle had become surmountable, and the work became logistical.

It is beyond the scope of this article to persuade the reader of the value of studying the history of medicine. Rather, the article focuses on the quandary of awarding CME at history of medicine conferences. Others have written eloquently of this struggle. Prior to the 2010 AAHM annual meeting in Rochester, Minnesota, Bruce Fye, former president of the American College of Cardiology, wrote in a letter in support of CME:

History teaches many valuable lessons that can be incorporated into medical practice. The history of medicine serves several useful functions today, when doctors live and work in an environment of escalating expectations, eroding autonomy, and decreasing discretionary time. Understandably, many doctors are concerned about the future of medicine as they watch so many powerful political, economic, and social forces transform medical practice, research, and education (10).

Jacalyn Duffin, a physician, author, and passionate supporter of the history of medicine, chronicled the CME quest, observing:

Not only does it illustrate how current standards came into existence; its pursuit is a mirror of clinical practice. History is predicated on the idea that things change. It proclaims the importance of life-long learning; its method—question, evidence and interpretation—reflects diagnostic reasoning (11).

Her book, *Clio in the Clinic: History in Medical Practice*, brings a pragmatic realism to the history of medicine in the form of applied medicine (12). Physicians particularly enjoy case-based approaches. History of medicine can be taught that way, a method epidemiologists and public health officials use to good effect. For example, Kushner's work on Kawasaki's disease, which involved reapplying an updated case definition, allowed

clinicians to recognize late effects of the disease that had been missed (13). That is applied history and a reason to keep teaching history of medicine for CME credit. This is not your father's history of medicine paradigm.

Numerical results

To the authors' knowledge, this is the first large-scale effort implementing this type of CME approach. Since there are no prior data, we elected to examine our acquired information to see what we could discover, as quantification may shed light on a subject when least expected. Einstein has noted in a quote inconclusively attributed to him, "Everything that can be counted does not necessarily count. Everything that counts cannot necessarily be counted." On the other hand, "Academics always want to show we're serious these days by talking numbers. And two problems arise when we do that. We get the numbers wrong, and we forget that numbers can't tell us everything" (14). Regardless, numerical data can be an instructive and informative start.

The conference was attended by 351 registrants, of whom 26 (7%) were MDs. Of the physician registrants, all submitted requests for CME credit. Credit was based on a narrative summary of each presentation for which credit was requested. A total of 370 narrative statements were submitted and studied by a physician from the host university in charge of CME for this annual meeting, as designated by the AAHM. From this review of individual presentation requests, 56% were accepted and 44% were rejected. The average was 14.2 requests per physician, with a range of 3 requests (2 people) to 28 requests (1 person). Eight physicians submitted 21 or more requests. The highest acceptance rate was 100% (3 of 3). The lowest acceptance rate was 0% (0 of 12 and 0 of 3).

The primary reason for CME rejection was failure to follow the instructions: "Describe how this presentation addressed your current practice-based needs. How will you use the information presented to 1) change/impact how you care for your patients; or 2) improve your medical administrative skills; or 3) enhance your research skills." The specific failure was documenting how the talk could be utilized to enhance skills in the three categories above. Most rejections resulted from the applicants limiting their remarks to a simple summary of the presentation. There were two rejections for illegibility. Of the submissions approved, 45% were approved for patient care, 27% for medical administration, and 21% for research. A handful, 7%, were approved in multiple categories. The *Table* provides samples of the responses.

Approximately 130 talks were delivered in the academic sessions. The lunch sessions, the Fielding Garrison Lecture, and the plenary session featuring two internationally prominent public health physicians were not included. This was an administrative oversight, as the forms were not provided in those locations. The academic sessions lasted 90 minutes and typically featured three speakers and sometimes two or four. The maximum number of talks one could attend was about 36. Thus, the maximum possible number of awarded CME hours was 18 hours at the rate of 0.5 CME hours per presentation. For this meeting, the maximum number of CME hours actually awarded to a participant was 10 hours. That person submitted 23 requests, of

Table. Examples of narrative critiques and the associated CME outcome

Category	Quotes
Offered no substantive reasoning as to why the presentation was useful; rejected for CME credit	<ul style="list-style-type: none"> • Beautiful preamble on the history of vaccines—very related to my interests. • Very interesting epidemiologic data on clothing and infectious disease. • Helpful presentation for clinician-historians.
Provided substantive reasoning; received CME credit	<ul style="list-style-type: none"> • Wow! A beautiful example of how a good observer who questions assumptions can discover something entirely new. Teaches me to look past assumptions. • I am a physician and historian; understanding the origins and controversies regarding disciplinary boundaries' history is crucial for my teaching and for my knowing how to bridge disciplinary boundaries in my medical school teaching—where I will be teaching about the non-“science” factors in the development of medical specialties—as well as in practice in collaborating in care with other specialties. • Reinforces clinical inclination to have a great skepticism about surgical referral unless one has positive knowledge of a surgeon's skill and judgment. • Use to consider timing of medications. • Increased perspective on duty-hour limitations and stresses on medical trainees. • Thoughtful analysis of the epidemiology of CHD [coronary heart disease] this past century. Helps me to think about changing risk factor profiles in my patients over those decades. • Great paper! Raises issues of celebrity endorsements of public health initiatives and potential personalities to distort the real agenda through pseudo-scientific arguments. • Contemplate play as a therapeutic intervention. Contemplate human reflex to mock disability embedded in children's games. • An important discussion about malaria, health, control and treatment. It brought out the need to explore humanism in the care and treatment of this disease for the overall public health. Should help me understand and incorporate humanism into the care of patients. This is also important to medical administration skills and expands my understanding of public health research. Also illustrated the importance of cost and value in health. • Raised issues about the real health aspects of obesity on medical care and health in general that will help me address obese patients in practice and the true impact of their weight on their health. • Henle-Koch causal rules—it was nice to put a name to this idea. I am often disabusing patients of causal relationships based on their faulty connections between two events with only a temporal relationship which does prove causality. I frequently review causality with my patients. I can do so more confidently now. I also give talks that rely on data from observational epidemiology—where causality is typically controversial. • Narcotic prescription writing is often a distasteful and unpleasant problem in my office. I am reminded to maintain a skepticism of complaints, seek objective evidence to support my diagnosis behind the pain and be alert, as always, for diversion.
Substantive comments on socially and politically charged topics showing the clinically empowering information imparted; received CME credit	<ul style="list-style-type: none"> • Evolution of patient-centered choice in sperm selection—interesting case study for any patient-centered approach—social forces of women's health movement and gay-lesbian movement. • Fascinating discussion of drug and pharmaceutical policy. Makes one reconsider the impact of racism on drugs of choice. • This session was informative for my medical school teaching in the medical humanities, particularly the medicalization of social problems, the stigmatizing of poverty and “otherness” and the ways medical interventions have been used (disproportionately to certain groups in the population) punitively. It will inform my practice especially regarding the differential tendency to medicalize (or dismiss) particular conditions differently in different populations (health disparities). • The interaction of the drug industry and the tobacco industry on recommendations to quit smoking for all patients will help me counsel my own patients concerning tobacco use. • The stress for women over the years in assessing appropriate pregnancy options—including abortion—continues into the present. Helping my female patients cope with present and past trauma related to this will be helped by understanding the political climate concurrent with their traumas.

which 20 (87%) were approved. The average number of CME hours awarded was 3.98 hours. Had all 370 CME requests been granted, the average would have been 14.23 hours per physician requestor. Fourteen talks did not elicit a request for CME.

Follow-up

In retrospect, we realized that one category was noticeably absent from the form: teaching. We believe that should physicians learn something or discover information that does not clearly fit

into the above categories but enhances their ability to teach medical students, residents, or colleagues, they should be awarded CME credit. Informally, the reviewers noted 13 critiques that could have stood on their own merit as enhancing teaching. When we later included teaching as an option for CME compliance at the Annual J. Willis Hurst Symposium, held at Emory University School of Medicine in September 2013, the results were similar to those at the earlier AAHM conference. At the Hurst Symposium, 41 of 59 attendees (69%) submitted 179 critiques, of which 91 (51%) were

approved. An average of 1.11 CME credit hours (range 0-3) was awarded. Despite a brief PowerPoint display explaining the new criteria and procedures, failure to follow directions was again the primary reason for denial of CME credit.

Lessons learned

One downside to this CME approach is the labor involved in reviewing the critiques. Yet for one arbitrator, who soldiered through 370 handwritten reviews of widely varying but mostly poor penmanship quality, the experience was heartwarming and informative. A common positive theme among the responses, especially for politically charged and socially complex topics such as abortion, gender issues, sexual orientation, and drug abuse issues, was the implication that the physician, possessed of this historical background knowledge, felt more empowered, confident, and informed when talking with patients personally struggling in these areas.

DISCUSSION

In our view, this CME experimental protocol with a premier national history of medicine conference, retested at a focused medical history symposium, was a success. Greater attention to following the rules for submitting CME requests would have led to enhanced success at both meetings. We hope the AAHM continues to use and refine this method and that other history of medicine gatherings adopt similar tactics. One future improvement will involve transitioning to an online submission format. However this process evolves, we feel we have made a significant and positive impact on validating the CME process for history of medicine gatherings. In doing so we think we have complied with the laudable and stated aims of the ACCME as follows:

The ACCME's purpose is to oversee a voluntary, self-regulatory process for the accreditation of institutions that provide continuing medical education (CME) and develop rigorous standards to ensure that CME activities across the country are independent, free from commercial bias, based on valid content, and effective in meeting physicians' learning and practice

needs. The ACCME accreditation process is of, by, and for the profession of medicine (5).

We will also be happy to hear from the US Senate regarding our progress.

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