

*Original Article*

## History of the Society of Medical College Directors of Continuing Medical Education (SMCDCME): The First Twelve Years, 1976–1988

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**Abstract:** *The Society of Medical College Directors of Continuing Medical Education (SMCDCME) came into existence on April 2, 1976. This review derives from memories of the author and some other past-presidents of the organization plus information from remaining documents. It recounts how societal forces, acting upon medical college CME directors and their parent institutions, prompted the formal organization of the group. Major activities and themes are described that occupied the organization during its first 12 years of challenge and accomplishment.*

**Key Words:** Continuing medical education, history of SMCDCME, historical review

*Not to know what has been transacted in former times is to be always a child. If no use is made of the labors of past ages, the world must remain always in the infancy of knowledge.*

*Cicero*

Organizations mature, as do individuals, in a regular, describable, and fairly predictable manner. In contrast to individuals, however, organizations are endowed with no DNA but are shaped by forces collectively termed “society,” which in turn becomes modified by the presence and activities of the organization. Although lacking its own DNA, an organization progresses through intervals and events that might be described as pre-conception (vaguely potential), conception, gestation, birth, childhood, adolescence, and maturity, at which time the genealogical interest begins to flower. Thus, President James Leist in 1990 decided the SMCDCME needed archival material

that was organized and safely stored, a historian, and a recounting of its history.

He persuaded me to accept that task. The existing materials available to me were folders in a large box, stored at the first “permanent” secretariat (the Continuing Medical Education [CME] Section of the American Medical Association [AMA] in Chicago). After perusing the contents and discarding many travel schedules, duplicated documents, and other ephemera, I realized that the “archive” consisted almost entirely of files from Dr. George Race, who had been Secretary-Treasurer in 1981 and then President in 1982–1983. Dr. Race recently wrote me that these incomplete files represented his personal archives to 1988, while all the formal Secretary-Treasurer records to the end of his term in 1981 had been forwarded to his successor. I have been unable to locate that material or any archival accumulation since then. I was able, however, to augment that limited material with a small personal file I had kept after I completed my own 2-year term of office as Secretary-Treasurer in 1980 and became President-Elect and sent all the Secretary-Treasurer’s material to Dr. Race. I have also recalled certain details

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at the time of this writing, 1994–1995; a few additional memories have been provided from some of the other SMCDCME Presidents who served during that opening epoch. These sources permit telling the story of the Society’s founding in 1976 and its first dozen years — and a few details after that — with sufficient completeness to satisfy all who are curious but not genealogically compulsive.

### **Preconception**

Those interested in the earlier historical development of CME in the United States should consult the excellent monograph by Robert Richards, *Continuing Medical Education*.<sup>1</sup> That summary ends at about the time the SMCDCME was approaching its conception. A complete history, to begin in the 1960s, could likely fill another scholarly monograph, especially if fortified with an appropriate storehouse of footnotes and appendices. I do not intend such a project, but will essay instead a summary not organized by strict chronology nor biographic vignettes of officers and other leaders, but by a series of themes, within which some of the milestone events and persons will become apparent.

In 1980 President Malcolm Watts appointed a history committee (Gail Bank, PhD, Chair; Phil Manning, MD; and Jacqueline Parochka, EdD). In 1982, the committee presented to the executive committee its report, which summarized in considerable detail the major events that culminated in the founding of the SMCDCME in 1976. The executive committee, seeking a synopsis suitable to include in an informational brochure about the society, asked Dr. Bank (this time assisted by Minerva Brown, MSW, and Mr. Robert Neth) to draft a much-abbreviated historical statement. That version was submitted to the executive committee in 1984. Neither version has been published or generally distributed, to the best of my knowledge, even though its information is illuminative. Three informational brochures appeared later. Although not dated, they list names that imply dates of about 1987, 1990, and 1993. The

medical schools represented by the voting members are enumerated in each brochure and number, respectively, 119, 120, and 121.

### **Conception and Gestation**

The Association of American Medical Colleges (AAMC) formed a committee on Continuing Medical Education (CME) as early as 1950, although by 1960 only 18 medical schools had an identifiable CME program. That number grew rapidly, stimulated by state legislative decisions that required CME for re-registration of the medical license, by specialty societies (pioneered in 1947 by the American Academy of General Practice) that required CME for continued membership, and by the federally funded Heart, Stroke, and Cancer Program (better known as The Regional Medical Program), which provided financial support for developing many medical college CME programs. Such developments were probably major stimuli that prompted W. Albert Sullivan Jr., MD at The University of Minnesota in 1960 to convene a 2-day meeting to which all medical colleges with identifiable CME programs were invited. Its theme, “How to Get Medical Schools Involved in CME,” was followed later that year by a meeting at Albany, NY, convened by Frank Woolsey Jr., MD.

In 1969, the AAMC’s committee on CME recommended that the AAMC place CME among its primary concerns, that it urge its member schools to recognize CME among their major responsibilities, and that the AAMC establish an administrative unit to support CME activities arising within its component medical schools. These recommendations were not accepted and the AAMC in 1971 discharged its CME Committee. In 1974, however, the Steering Committee of the AAMC’s Group on Medical Education (GME), responding to growing CME pressures, agreed to expand its interests to include “the continuum of medical education,” thus seeming to include CME in its administrative and programmatic purview. The GME by then contained so many component interests that the administrative leaders of medical

school CME seldom felt their needs to be adequately met within the GME.

The major events, viewed at this distance, seem to be related to the following points: (1) the growing activity and responsibility that many medical schools were developing for CME in the 1950s and 1960s; (2) the troubled sequence of events that characterized the inability or unwillingness of the AAMC during those years to respond adequately to the growing pressure from the CME directors of medical schools; (3) the grass roots origin of a highly informal group assembled at a retreat to share common problems and activities (begun at the invitation of Jesse Rising, MD, CME director at the University of Kansas — an activity begun in 1967 that seemed so welcome to those attending that it became an enlarging annual event that was hosted in subsequent years by the Universities of Wisconsin, Michigan, Missouri, and others, and was ultimately incorporated from 1981 into the SMCDCME programs); (4) the evolution of a second annual gathering, rather more focused on research issues than the “retreats,” convened first in 1971 at Palm Springs, CA by Phil Manning, MD, CME director at the University of Southern California. The combination of felt need for organization, self-help, and recognition (even from many medical college deans and other faculty members), coupled with the too-little-too-late response of the AAMC (which might have seemed the “natural” base for such a group of academic professionals functioning in the world of CME) finally led the activists — activism being a characteristic of American society in the late 1960s and early 1970s — to form an independent organization.

### **Birth**

At one of the Palm Springs meetings, interest in forming an independent organization began to crystallize. When it was learned, via help from the AMA legal office, that incorporation was not required, Dr. Manning and others felt that an opportunity for decision-making should be

extended to all schools. That invitation led to a discussion and debate at the November, 1975, meeting of the AAMC in Washington, DC. The well-attended meeting generated much enthusiasm for forming an independent membership organization. Dr. Manning was chosen as the interim president of the fledgling organization. All schools were invited to attend the next “Palm Springs meeting” at Carlsbad, California, in April, 1976. Dr. Robert Combs, head of CME for the University of California at Irvine, presented a draft constitution and by-laws, which were debated, modified, and then adopted on April 2, 1976. The SMCDCME was now off and running with Dr. Manning elected as its first president.

### **Childhood**

Thus, the customary formative steps of many organizations were fulfilled for the SMCDCME: a sense of need, a period of struggle and attempted accommodation, a decision to create the organization, and the formal adoption of a constitution and by-laws containing definitions of purpose, members, officers, committees, dues, and procedures. Then, as usual in a successful organization, additional events and activities prompt internal communications that grow into a newsletter and even a published journal. A young organization, if successful, expands its functions and influence, tends to lobby and raise funds to support its expanding vision of itself, and may consider absorbing or joining other organizations. Such events are part of the story of the SMCDCME.

The original constitution, adopted April 2, 1976, was amended during the first years in 1978, 1980, 1984, 1986, and 1987. A comparison of the original document with the still later version of October 21, 1990 reveals that the most important modifications involved members, officers, and committees. Categories of membership expanded from regular and honorary life members to include associate members, continuing members (no longer eligible for membership because of a change in professional activities, but wishing to continue

the affiliation), emeritus members, corresponding members (and by 1994, student members). Officers originally included a president-elect; the position later became modified into first and second vice-presidents, while the original hyphenated secretary-treasurer became two offices, assisted by an executive secretariat. The founding constitution specified only three committees: executive, nominating, and finance. Later versions added committees for program, membership, and research. Ad hoc committees for special purposes could always be created. Throughout the several modifications, the purposes of the society remained constant: “To establish the national forum for The Society of Medical College Directors of Continuing Medical Education, and to improve patient care through Continuing Medical Education.” Thus the goal-orientation for CME to do more than merely “provide education,” but to produce better care for patients, was present from the outset. This concern for “payoff” in health outcomes indeed represented the adopting of a new posture. Available documents, plus my memory of those years, testify how faithfully the leaders and members adhered to the spirit and procedures of its original and subsequently amended constitution.

Throughout the 1960s and 1970s the rapid expansion of CME increased the sense of need for standards, accreditation, and other measures of quality. In addition to events already mentioned, the AMA in 1968 activated a voluntary program to acknowledge individual CME participation, called the “AMA Physician’s Recognition Award.” Other events, in tandem with the beginning of the SMCDCME, produced other CME organizations with which the SMCDCME would ultimately relate.

By 1988 most of the U.S. and Canadian allopathic medical schools were represented among the voting members of the SMCDCME. Beyond the factors already mentioned that stimulated CME growth lay the movement toward obligatory CME for renewal of certification by many specialty certifying boards and the development of the Accreditation Council for CME (ACCME), a relatively

independent organization with its own convoluted history and structure, which provided a standard of quality and prestige. These developments may be contrasted with the situation in 1967, when Dr. Rising convened the first “Retreat group,” consisting of 36 persons, who attended with invitations extended by hearsay and word-of-mouth. The Society at its 1987 meeting celebrated the first Retreat with a special twentieth anniversary program honoring that early effort.

Although always related to medical schools, the members of the SMCDCME have been individuals, never institutions, even though each voting member had to be certified by the respective collegiate dean as the individual in charge of that school’s CME program. Thus the voting membership could never exceed the number of existing allopathic medical schools. The category called associate membership — persons acknowledged by the voting member as an important contributor to the school’s CME effort — could potentially rise to several times that number of members.

A photograph taken at the founding meeting in 1976 shows 33 persons, identified on an attached sheet. The membership list issued in the fall of 1979, however, lists 35 persons as charter members plus 4 other helpful persons identified in a one-time category called “advisors”: Rutledge Howard, William Nelligan, Harrison Owen, and Emanuel Suter. That 1979 directory tallies 61 voting members plus 21 charter voting members, 21 associate members, 6 simply as “charter members,” and 2 continuing members. By contrast, the 1989 directory shows not only a growth in numbers over the decade but also the effects of age and changing activities of members: 86 voting members plus 5 charter voting members, 60 associate members, 4 simply as “charter members,” 17 continuing members, 5 emeritus members, and 2 honorary members.

### Adolescence

The organization soon recognized its need to become a 501(C)3 tax-exempt organization in the

eyes of the Internal Revenue Service. This would permit tax-exempted charitable donations and liberate the organization from the hazard of federal tax intrusion into its treasury. The lengthy process began when this author was secretary-treasurer and was completed in 1982 by Dr. Race.

Although the young organization had a very modest treasury, another important “protective” detail was the bonding of the person who functioned as treasurer. This bond was first obtained by this author in 1980 and has continued. Strangely, those administrative tasks proved relatively easy compared with obtaining and distributing a telephone credit card account for the use of officers. Although Dr. Race obtained a telephone number and cards for the officers, the system died an early death, probably because it was rarely used and probably made extra trouble for the secretary-treasurer.

More frustrating than the above details was the evolution of a satisfactory logo. Clearly, appropriate stationery and logo would be valuable to help the organization’s sense of identity. As secretary-treasurer, I invited suggestions from the members and also asked a medical illustrator at the University of Iowa to create a choice of possible logos. The process proved surprisingly difficult and, especially in retrospect, consumed an extraordinary amount of discussion time at meetings for the first few years. Part of the difficulty probably related to the very name of the organization, which many people sought to reduce in length and simultaneously to produce a pleasing acronym. Those efforts failed utterly. The logo finally adopted would hardly win any graphic design prize, but allowed a political compromise and served the organization throughout and beyond the first 12 years (President J.S. Reinschmidt failed in another attempt to revise it in 1986).

Almost from its outset the young organization found itself relating, or failing to relate, to cognate organizations, most particularly the AAMC, the AMA, the ACCME, the American Hospital Medical Educators (AHME), the Alliance for Continuing Medical Education (ACME), and the publishers, ultimately, of the journal *Mobius* and its

successor, the *Journal of Continuing Education in the Health Professions*.

The relationship to the AAMC, as described earlier, was rocky in the early days. Once the SMCDCME was firmly established, however, its officers began to assess the possibility of relating to the AAMC for obviously appropriate connections. Yet, out of a feeling of youthful vigor and independence, perhaps mixed with a little spitefulness, they wanted to run no risk of losing the newly earned status of an independent organization. When the administration of the AAMC was contacted, its chairman, Dr. John Gronlund, and vice-president, Dr. John Sherman, suggested at an SMCDCME plenary meeting that since the voting members of the Society were all faculty members at medical schools, the organization might seek membership in the AAMC component named the Council of Academic Societies (CAS). The posture of Drs. Gronlund and Sherman seemed welcoming in that regard, and so the SMCDCME began a lengthy process to make itself appropriately constituted to meet the requirements for admission to the CAS. Once these details were finally completed, the submitted application was rejected, largely on grounds that the Society’s members were functioning as administrative officers rather than as faculty of a clearly defined discipline. (Becoming a “clearly defined discipline” was one of the most important developments of the early years.) This frustrating sequence once again kindled angry feelings in many of the members who had lived through the organizational years. A reapplication ultimately was accepted, however, in 1989. Since then the Society has been an active member, sending two representatives to the regular meetings of the CAS, and in that way helping to increase the voice and visibility for the SMCDCME in the CAS and its parent AAMC, as well as bringing information and issues back to the Society.

In the middle 1970s the AAMC had assigned Dr. Emanuel Suter a liaison role, and indeed he served well in that regard, attending meetings of the Society and performing constructive liaison

functions, even though his parent organization granted few accommodations. Gradually, however, the GME of the AAMC, which had earlier chosen to include CME within its spectrum of medical education, began conversations with the Society, leading ultimately to joint symposia and colloquia at the AAMC's annual meetings. After the retirement of Dr. Suter and a brief hiatus, Dr. Louis Kettell, formerly dean of the Medical School at the University of Arizona, who had become a senior AAMC administrator, sought to smooth the relationship. He did that well for about 1.5 years, until his premature death in 1992. (The AAMC link was helped again when the AAMC Office of Educational Affairs under Ms. Brownell Anderson established the second executive secretariat for the Society.)

In its early years the SMCDCME had little direct contact with the AMA, although a few members were relatively active because of some other role they filled. Once the AMA established a "medical school component" in 1977, many Society members were named by their respective medical school deans to attend AMA meetings. This seemed a constructive step. In 1988, Dr. Dennis Wentz, then director of CME at Vanderbilt University, became full-time director of the AMA's Division of CME. Because Dr. Wentz had served as president of the SMCDCME, this linkage was highly fortuitous. One of the specific benefits was Dr. Wentz's ability to give more visibility to CME concerns within the AMA. He also negotiated with Society President Dale Dauphineé for his AMA office to serve as the first "permanent secretariat" for the society.

The ACCME, because it set standards and judged quality for institutions that wished to be accredited for CME, was always important to the Society. The medical schools themselves, by the operating procedures of the ACCME, were always to receive their accreditation directly from the ACCME. Whenever that organization changed its philosophy, rules, or procedures, the medical schools felt highly interested and occasionally unhappy or threatened. Although the SMCDCME

was not a parent organization for the ACCME, some Society members had served as members of the ACCME or on its review committee, or had participated in its site visits. Relationships, although indirect, always seemed cordial. The small staff of the ACCME was cooperative in making presentations at Society meetings concerning their interests and activities, and Society members cooperated with various tasks of the ACCME.

The AHME had a small overlap in membership with the Society, but the activities of the organizations were distinct. Occasional inquiries explored whether the AHME and the ACME might wish to hold meetings jointly with the Society to facilitate scheduling and reduce expenses for persons who were members of both organizations. The ACME's interests were allied to the Society, but its membership was far less narrowly restricted. Many Society members were also actively involved with the ACME, or if not members, attended its annual meetings. Occasional conversations looked toward merging the Society with either the AHME or the ACME or with both, but the members of the respective organizations seemed to feel that the missions and activities were distinct enough that an actual merger would be inappropriate. After a moderate amount of jockeying, however, the Society joined with the ACME to sponsor the *Journal of Continuing Education in the Health Professions*. This move not only increased the sense of kinship, at least among the leaders of the organizations, but also provided practical support to the editors and publishers of *JCEHP*.

In the early years of the Society, several committees sought to draft documents that were felt to be important in assisting members or helping outsiders identify the role and the importance of the Society and of CME. Dr. Malcolm Watts had called on members informally in evolving "The Anatomy of CME," published in the first edition of *Mobius* (1981). The *Essentials for Medical College CME* and the *Society Goals for the 80s* were both adopted on May 19, 1981. At the annual meeting the following year (May 18, 1982) the organization adopted *Guidelines for Excellence of*

*Medical College CME.* These documents, meant to assist individual members in their personal work and the work of their respective schools, were seen as major progressive steps regarding the quality of continuing education, which in turn was viewed by the organization as making a significant contribution to the health and well-being of the nation. These documents and the processes that led to their appearance assisted the organization and its members to an expanded consciousness of their work as an independent discipline and an altruistic force in society. Another important internal document for self-guidance was the *Strategic Plan*, developed under the guidance of Dr. George Smith and ultimately adopted on October 29, 1989.

From its early days the organization believed that sharing of information among the members about many issues was highly valuable. The spirit of the Retreat groups, so important in leading to the founding of the Society, served this purpose. Many other modes of sharing information, such as procedures, fees, and remedies for internal problems, were employed at meetings within plenary sessions, small group discussions, or during casual corridor or social conversation. A more quantitative mechanism to understand the medical colleges' CME behavior took the form of an annual survey of members. For the early years, the questionnaire arose at the University of Nebraska and was subsequently shepherded by Dr. Van Harrison at the University of Michigan. The results from the sometimes complicated questionnaires were then returned to the members. Because of the remarkable variation in the origins and operations of medical school CME units — leading wags at times to say “when you have seen one CME shop, you have seen one CME shop” — it was difficult even to pose the survey questions so as to draw forth answers from which generalizations could be made. But although finding it hard to interpret or apply the summary results, the members welcomed these annual surveys either to suggest new ideas, or perhaps simply to soothe concerns about how closely one's own organization and its

activities lay near the “mainstream” of medical college CME.

Once the Society had become securely established and had adopted some stability of its procedures, the desire arose to attempt collective research, especially prompted by the vision and impetus of Dr. George Race during his presidency. Reminding the members that research was an activity especially available to, and expected of, academic faculties, he predicted that our own status, recognition, credibility, and respect, singly or collectively, could be assisted by performing high quality research. Apart from a sense of obligation, self-seeking, or curiosity, the world of continuing education needed well-performed research to answer many practical concerns. The nature of the Society with its broad representation from medical schools not only allowed, but invited, certain kinds of research, which would have been difficult to impossible for individual persons or institutions.

Dr. Race appointed a research committee headed by Dr. Harold Paul of Rush Medical School as chairman, a step that began a continuing process of concern, activity, and success for collaborative research under the sponsorship of the Society. An emphasis on research also allowed a fuller participation by a number of associate members who had special interest and talents in educational research, an expertise not as clearly present in most of the more senior, clinically oriented, voting members. Those especially active and interested in such research included Drs. Robert Fox, Paul Mazmanian, David Guillion, Nancy Bennett, Wayne Putnam, Jocelyn Lockyer, and David Davis among many others. Some of the earliest projects, and ultimate successes, resulted from their dedication and continuing work. A particularly important contribution was the nationwide study of factors that produce change in the knowledge, attitudes, and behavior of physicians. It ultimately found publication as the monograph, *Changing and Learning in the Lives of Physicians*,<sup>2</sup> in 1989, edited by Robert Fox, Paul Mazmanian, and Wayne Putnam. This extensive study, a data-

based analysis of the factors that lead physicians to change their patient care procedures, emphasized the value of research to the world of CME, and modified much of the subsequent thinking about the environment, methods, and expected outcomes from CME effort.

A related activity was a continuing education forum that focused on the process and outcomes of Research in CME (RICME). The several RICME conferences were held in alternate years: 1986, at Montreal, organized by Drs. Dale Dauphineé and Dave Davis; 1988, at Los Angeles, organized by Dr. Phil Manning; 1990, at San Antonio, organized by Dr. Ciro Sumaya; and 1992, at Birmingham, AL, organized by Dr. George Smith. The conferences provided a forum for members to illustrate and disseminate their work, plus opportunities to acquire inspiration and methodologic finesse from other members. Preparing such conferences and guiding collaborative research under the aegis of the Society are complicated processes, slow to mature, yet the results can be unique, obtainable in no other way, and gratifying to those who have been active in the projects.

From its founding the organization's growth continued, with new members of several categories being added to the list; the membership directory gradually became an information resource instead of simply names typed on a sheet. The annual expenditures and the residual funds increased. The treasurer eventually drew attention to a sobering possibility: the Internal Revenue Service might not look kindly on a supposedly educational/charitable organization with its residual funds and its income exceeding approximately one year's annual expenses. The organization's treasury was not in great hazard of exceeding that amount, but there was a certain pleasant conundrum in reaching the place where such matters needed to be thought about. The use of funds eventually to attract other support to a research-and-development fund remained a pleasing future prospect.

A major purpose of the organization from the outset was to provide professional development opportunities for its members, that is, continuing

education for the continuing educators. The programs, therefore, have always dealt with topics of practical importance and attempted to sensitize members to evolving trends and issues. An appropriate mixture of guest and member resource persons, panel discussions, and small group meetings were important modes. Some members wryly observed on occasion that in spite of our androgogic utterances, our format was quite conventional, resembling most other contemporary CME programs, and that, somehow, we should be more oriented to individualized work and problem-solving. These considerations, valid though they seemed, made little change in the structure of the programs.

Gradually more committees and ad hoc groups evolved for particular kinds of problems. The Retreat, which had been so important in catalyzing the Society's formation, continued as an appendage to the regular meetings, but subsequently gained a more integral status. The sponsorship of the RICME meetings provided impetus and example as well as techniques and results for all the members, but particularly for those with research interests. The evolution of a publication, first *Mobius* and then its successor, the *Journal of Continuing Education in the Health Professions*, and subsequently in January, 1987, the arrival of an expanded newsletter called *Intercom* signaled the full flowering of the organization.

During the first 12 years the record-keeping fell largely to the individual named secretary-treasurer. As the number of members and the amount of activity grew, that post was eventually split into two functions with many routine secretarial functions undertaken by an executive secretariat.

From the outset of the organization, and especially regarding the push-and-pull tensions with the AAMC, an awareness gradually bespoke the need for cooperative work with other organizations. Opposite this tendency toward cohesion and cooperation lay the hazard of absorption and disappearance, a hazard particularly worrisome in the earlier years, before the members felt fully secure about the need and benefits of a truly independent



organization. Throughout the first 12 years, the Society was able to maintain and secure further its sense of independence while holding discussions about cooperative activities with other organizations, each having its own perspective and needs in the face of considerable overlap of members and functions.

In these early years, the SMCDCME was committed to creating a greater visibility and influence for the discipline of CME and also for its members. This psychological identity was no doubt important, so that before long the organization was serving not only as an ego-booster, but also a clearinghouse for information about jobs, career opportunities, status (individually and collectively), and matters dealing with fees and operating budgets. Many problems, in the early years, attracted major attention from the Executive Committee, other committees, and from the members at general meetings. These involved, for example: accreditation; budgeting (of CME shops, fees for conferences, and courses); status and prestige and how these could be obtained by individual CME directors and their offices at their respective schools; adjudicating the proper relationship and loyalty of medical school teachers to the programs of their own institutions; the prestige of the profession of CME in the eyes of faculty colleagues and other organizations; the proper posture of CME toward industry and the appropriate, ethical use of its financial support; and the relationship to other closely allied professional societies.

Among the special task forces or ad hoc committees established to address timely issues was the important recurring committee charged to study the appropriate relationship between CME purveyors and the potentially conflicting interests of pharmaceutical and manufacturing companies, whose attitudes and budgets proved important to the operation of many CME units. Society members varied in their sensitivity to these potential or direct conflicts of interests. As president, Dr. George Race first appointed a group to explore the problematic relationships. Members particularly

active in these discussions and evolving policies have included Drs. Glen Garrison, Martin Shickman, Dennis Wentz, Phil Manning, and Robert Cullen. By the late 1980s, consciousness of this problem had blossomed fully and the concern spread not only to other medical organizations engaged in CME but became a hot issue in the halls of the Food and Drug Administration and even in Congress.

The Society's president in 1990, Dr. Robert Cullen, established an informal advisory group of the organization's past-presidents. Its official functions were nil — simply to meet for breakfast or lunch during the regular meetings and reflect on activities of the organization. Its unofficial function would be to offer reactions and counsel to the current president. This group first convened in San Antonio on the morning following an evening's socializing at a nearby ranch where armadillos and armadillo racing entertained guests. One of the past-presidents suggested the group be called the "Armadillo Society," out of regard for the relative sluggishness and unimportance of its members. The aptness of that name found immediate approval and the group has enjoyed continued existence. Although having no formal status, no authority, and no documented evidence of effectiveness, the anecdotal self-testimony to its diffuse benefit continues to cheer the aging members.

A phenomenon apparent by 1988, after a dozen years' existence and continuing even more after that, was the gradual transition from the relative elitism of members who were directors of medical school CME organizations (voting members) to a more egalitarian participation of all members. Along with this shift, and partly because of it, the membership quickly began to grow and change. The election of associate members, many of whom were not physicians, to be officers and directors became prominent. Another gradual change, away from CME directors being physician-faculty members, led to greater participation and leadership by persons more trained in education, educational research, and administration. Many of them had extensive work experience in CME and

were knowledgeable about operating a medical school CME unit and the relevant persons and procedures needed in order to be effective at their own schools. This development produced an organization that increasingly exhibited the professional characteristics associated with the broad arena of continuing education. Thus, educational theory and methods, research techniques, learning and behavioral outcomes, leadership and management, ethical considerations — all received increasing attention. To what extent these foci can flourish and still permit a vision of clinically oriented patient-care improvement will remain a constant challenge to the organization and its leaders.

Furthermore, the often transitory trajectories of individuals working in medical school CME became more conspicuous as the 1980s progressed. This evolution and transience is evident, in part, by new members assuming responsibilities; of the 36 persons who attended the first Retreat meeting in 1967, 18 (50%) were no longer active in this sort of work at the time the twentieth anniversary of the Retreats was celebrated in 1987. Many other persons had entered and then left the CME arena and the Society in those years. The deaths, retirements, and career changes that accounted for such attrition were accompanied by the previously mentioned greater conspicuousness of persons whose background lay not in medicine, but in educational administration, psychology, social work, testing, and marketing.

A mark of maturity appeared in the late 1980s when the Society began to bestow honorary membership on individuals felt deserving of that distinction. The first recipient of such an award was Professor Cyril O. Houle, marking the Society's recognition of outstanding contributions by persons in the general fields of continuing education, or in medical education and more specifically in continuing medical education.

Throughout the Society's existence, matters of communication and publication have been highly important. Initially, messages to the members consisted of letters from the president, secretary-treasurer, or regional representatives. Such mailings

contained mainly announcements and arrangements for forthcoming meetings; however, agendas and minutes for both executive committee meetings and general membership meetings were included. At variable intervals a membership directory appeared. As mentioned earlier, an effort was made to develop an explanatory brochure describing the organization. A brief undated bi-fold brochure (8½" × 11" sheet and modified at least twice) gave an explanation, but it did not include the historical information available in previous reports from Gail Bank and his helpers. The "newsletter" format by 1987 became transformed into the more formal bulletin, *Intercom*, first edited by Harold Paul and assisted by Dene Murray. It contained news items, announcements, information about research, personal items about members, editorial comments, and so on. Members of the Society, acting alone or in small groups, also published articles and editorials in various journals, although to my knowledge no formal compilation of such items has appeared. Neither does our archive contain copies of such publications.

In 1981 a journal appeared that was dedicated to "lifelong continuous learning in the health sciences professions." Its title was *Mobius*. Edited by Lucy Ann Geiselman, it was supported and published by the University of California at San Francisco. In 1988 this journal changed its name to the present *Journal of Continuing Education in the Health Professions*. Published commercially, it later became the official journal of the Society and of ACME. Subsequent editors were Malcolm Watts (1986–1991), William Felch (1992–1994), and the present editor, Robert Fox who took office in 1995. Several Society members have always served on its editorial board. This publication has served well as an outlet for ideas, work completed or in progress, emphasis on research, and personal and professional status and inspiration.

### **Maturity**

As with individual biographies, so with the Society; the passage of time plus vigorous activity led

to a sense of security and accomplishment. Many of the issues mentioned under the heading of “adolescence” continued into a period that might be called “maturity.” But individual maturity moves inexorably toward senescence and death. This Society, like any other that aspires to continuing life, must continually infuse energy to avoid Shakespeare’s description of a blind, toothless and otherwise deteriorating organism, and also to escape the downhill implication of the second law of thermodynamics that predicts entropic, chaotic demise. What will evolve must be told by a future historian.

Six years have passed from the end of my limited archival material until the time of this writing. As a result, certain trends and needs that will affect CME have become clear and CME will have to address them. These will require elaboration by a subsequent historian. They might include, however, the following examples: the enormous impact that evolving changes in the health care delivery system have on economic incentives (transition from fee-for-service to “managed care”); advances in techniques for measuring quality of care and health outcomes; the changes demanded by the information superhighway and long-distance medical services; alterations in training and the kinds of roles, status, and income attained by health care professionals; increasing recognition that technologic medicine, so eminent and successful in recent decades, must and will be better balanced with humanistic considerations of care as well as cure; the churning changes in responsibilities and sources

of support for academic health centers and the effect of these changes on the discipline of CME; and the way that all these changes in the medical and larger social environment will modify the interests, training, and roles of the professionals who carry responsibility for CME. The very lack of a satisfactory archive for the Society through these years is a problem. Any future historian will require substantial cooperation from organizational officers in order to write a comprehensive history beyond those first dozen years of excitement, challenge, and accomplishment.

### **Acknowledgments**

I am indebted to many persons, too numerous to list, for direct and indirect assistance in the story told here. Along with thanking James Leist, who pushed me to this task, I also appreciate the editorial suggestions and historical memories of some other members of “The Armadillo Society”: Phil Manning, Malcolm Watts, Gail Bank, George Race, J.S. (“Dutch”) Reinschmidt, Dale Dauphineé, and Robert Cullen.

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