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2003 Meeting Report:
How Does CME/CPD Work in South America and Asia?

Among Spanish-speaking countries, Mexico is one of the most advanced in terms of CME/CPD, said José Luis Arredondo, MD, PhD, Director of Clinical Research, Institute of Pediatrics, Mexico City, during a plenary session at the Eighth Annual Global Alliance for Medical Education Meeting, June 22-24, 2003.

CME providers must fulfill national CME standards. Board certification became mandatory in 2001, and most of the 48 certification boards currently re-certify their members every five years, explained Dr. Arredondo. The National Program of Updating and Academic Development to General Practitioners (PRONADAMEG), initiated in 1994, now has more than 10,000 participants, he added.

The U.S. has had a major influence on the development of CME in Mexico, Dr. Arredondo explained, as a number of Mexican opinion leaders have done their postgraduate work in the U.S. In addition, collaboration between Mexican and U.S. medical associations has been important in the development of CME programs.

Dr. Arredondo also gave an update on CME in other Latin American countries:

- **Argentina** - board certification is now mandatory, and re-certification programs are developing.
- **Chile** - the government and medical authorities are considering implementing CME and board certification rules for all specialists.
- **Costa Rica** - board certification is voluntary for almost all medical specialties, although it is required for employment and government institutions. Re-certification is required in six specialties.

In conclusion, Dr. Arredondo stated that CME is a growing trend in Latin America, which offers a good opportunity for print based and online CME providers to work with government health bureaus, medical schools and institutions, and private CME companies.

Brazil Creates an Oncology Community

Satellite broadcast technology has been an extremely effective delivery mechanism for bringing CME to hospitals throughout Brazil, said Frederico Perego Costa, MD, Director of Telemedicine, Hospital Sírio Libanês (HSL), and Brazilian Society of Oncology, São Paulo. The case example he described focused on oncology, but it would work for other areas of medicine as well, he said.

The telemedicine project was initiated at HSL's new cancer center in São Paulo, and when it was successful there, the next step was to reach hospitals across Brazil, said Dr. Costa. But, "Brazil is a large country with regional diversity," he noted. "The question was: 'How could we integrate such diversity to provide meaningful medical information and to standardize and improve medical practice throughout the country?'"

A combination of Internet and satellite technology is the only viable means to transmit medical education to hospitals across the country, he explained. In the HSL telemedicine program, case-based sessions are transmitted in real-time over satellite. Doctors in hospitals watch the program, and using their cell phones call in with questions and comments.

During a trial period of a year, from November 2001 to December 2002, the HSL telemedicine program produced 46 weekly sessions in oncology. Initially, about 29 physicians participated each week; that figure grew to 150 to 300 participants per week, becoming an integral part of the doctors' schedules, said Dr. Costa.

Because of the successful strategy, Hospital Sírio Libanês joined with Brazilian medical societies, the Health Ministry, and Conexa Medica to create the Brazilian Network against Cancer, a large CME project with accreditation that launched in February of 2003.

"Our idea is to create a seal of quality for doctors. The diversity of this new program attracts different public and private hospitals all over Brazil, giving medical societies more influence with the media and the government, building a necessary

platform for accredited CME," said Dr. Costa. In the future, the network aims to create affiliations with international institutions, he added.

Understanding China's Complexity

Westerners considering bringing CME to China, listen up! "In no way can this be done by walking in and baldly announcing, 'I'm here to rescue you.' That's considered extraordinarily offensive-and is indeed offensive," explained Gerald S. Lazarus, MD, Professor, Department of Dermatology, Johns Hopkins School of Medicine, Baltimore. Sponsored by the China Medical Board, Dr. Lazarus and his wife, Dr. Audrey Jakubowski, spent three years in China, from 1999 to 2002, serving as faculty at the Peking Union Medical School and as consultants at major hospitals and other medical schools.

First, Western CME organizations need to understand the complexities of China's healthcare system, Dr. Lazarus emphasized. There are 200 million people who are abjectly poor in China; 60% of Chinese people cannot afford to go to the hospital and 60% leave the hospital before they should because of financial constraints, he said.

As for the healthcare leadership system, "it is the classic homeboys network," he said, describing leaders as "benevolent despots." Typically, surgeons serve as presidents of hospitals; however, their jobs are frequently rotated. The system is highly politicized: "Even changing job descriptions involves political machinations that almost defy the imagination," he commented.

Medical education is authoritarian and lecture based. At grand rounds and clinical conferences, doctors present opinions, rather than evidence-based medicine. Because physicians are not paid much, they feel their education should be funded by pharmaceutical companies. This is good news for drug firms in China, he said, as these companies can get doctors' attention by offering only cheap pens, note books, and lunch instead of the trips to the Caribbean demanded by Western physicians.

Although currently informational systems are underused, the Chinese "have a love affair with technology," said Dr. Lazarus, which offers an enormous opportunity for CME organizations to provide training in technology, such as how to use information systems for delivering care, clinical decision-making, and running medical practices. CME organizations interested in working with China must make a serious commitment, he said, if they intend to make a difference. "You're in there for the long haul. Change is very slow." In order to develop relationships with China, you have to get involved on a national level, he added, by working with the Chinese Medical Association and the Ministry of Health.

Despite the cultural complexities and obstacles, Dr. Lazarus thinks it is crucial for Westerners to get involved in China. He predicts that China will become one of the world's superpowers and also believes that "it's a country that deserves our support."

Japanese Public Demands Accountability

In Japan, there is increasing pressure from the public for disclosure of physicians' records and to improve the quality of care, said Toshiaki Shichino, President, Synergy international Inc., Tokyo. The government lifted the ban on clinic/hospital advertising in April 2002, in part because of this public demand.

In another educational development in Japan, the Ministry of Health, Labor & Welfare has instituted strict requirements for specialty programs. Out of 46 accreditation systems, only 15 have been approved by the Ministry of Health, Shichino noted. Due to the stringent, new rules, even well-established medical societies are being left out in the cold.

The increasing public concern may also impact CME, Shichino said. "I cannot forecast when the Japanese CME system will be changed to a mandatory one. It's related to the political [situation]." While physicians prefer the freedom of a voluntary system, Shichino believes that a mandatory system is better.

Although he acknowledges that change will be difficult, he also observed that the growing public demand for improved care and disclosure of information about physicians and hospitals will create momentum for development of a mandatory system.