

The Frances Maitland Memorial Lecture 2005 Presented by George Oetting, EdD

Editor's Note: George Oetting presented the Frances M. Maitland Memorial Lecture at the Alliance's 30th Annual Conference in January 2005. The following is a text version of this lecture.

Multidimensional Mentoring

I am very honored to present the sixth memorial lecture to honor my dear friend and personal mentor, Frances Maitland. It is also a pleasure to see many of my old CME buddies at this luncheon whom I haven't seen in several years. For those who don't know me, I was involved in CME at the state and national levels from the late 70's to the turn of the new century. I am retired now, and would like to use this opportunity to reflect on the mentoring process as it has developed in CME.

First let's start it properly with a pre-course quiz. Please raise your hands to respond:

1. How many of you are CME rookies with very little experience?
2. How many have 1-10 years experience?
3. 11 and more years experience?
4. How many of you consider yourself CME mentors?

You'll find the definitions of mentoring vary greatly from the simple Webster pocket dictionary version; "to teach and advise" to more complex ones including words like guide, inspire, help, share, etc. Some emphasize the one-one relationship between a veteran and a novice. Many of you may have had this kind of mentoring relationship in your CME professional work.

Today, I want to expand and broaden that concept into several dimensions: horizontal, vertical and downward mentoring. Much of what you do and experience with others in your CME work is really mentoring. We may give it other fancy labels but it really ends up teaching others or being taught with much inter-personal action. Maybe this is too simplistic a concept to discuss, but it's my 20 minutes today, and I choose to use it to hopefully expand your concept of mentoring – to a multi-dimensional one. I will use my own CME mentoring experiences with Frances and others to illustrate my points.

Let's start with the traditional downward mentoring of an experienced CME'r helping a rookie. The Essentials workshops developed under Fran's leadership at the ACCME and the Alliance are classic examples of extending this type of mentoring to larger groups, utilizing other experts to help. Those of us who did these in the early days each took a couple Essentials and developed instructional materials, refined them until they eventually evolved into the well-organized offerings of today's workshops. It is evident from their current popularity that this will be a never-ending mentoring need. I noted in recent issues of the *Alliance Almanac* a special section called Reality CME, that uses a group of experienced mentors to provide one-on-one help to individual questions, which, in turn, educates all readers.

A very early example of this type mentoring was done by a famous AMA CME staffer, Rut Howard, in the mid-70's when he personally visited every state medical society to help them get their CME programs started, both as CME providers and reviewers of intra-state CME activities. This close-up, informal mentoring proved to be a major stimulus to get states involved in CME. When we went out later to review state accreditation programs, we found they needed additional help to get up to snuff because they had been left on their own for many years during the national power struggles to get the ACCME established. As a member of many review teams, I was told to just get the facts as objectively as possible and not get too involved. I and my survey mates occasionally ignored these instructions in the interest of helping a struggling society get on the right track – even to the point of

marching through the Essentials with them. Maybe you could term this “off the record” downward mentoring – in the higher interest of getting CME established properly. I’m sure you can all think of many examples of downward mentoring.

Let’s move on to horizontal mentoring with your colleagues at the same operating level. This is probably where most of your mentoring action will occur. The Alliance Almanac newsletter is a classic example of horizontal mentoring, with articles by various CME interest groups educating other Alliance members about their activities and interests, and colleagues with special expertise offering tips on survey design or better compliance with particular Essential areas.

Going back to medieval times in CME in the 1970’s, the AMA issued a great newsletter we could use to swap ideas. I once offered to trade our Alabama evaluation forms for those from other CME’rs. I got hundreds of creative samples plus lots of comments. One of the best was from a crusty MD in New York City: “My best course evaluation is to turn on the lights after a CME activity and count the number of Docs who are still awake”! In those early formative days we spent much time on the phone frantically asking, “How do you do this?” or “Could you send me a copy of the accreditation form you use?” One day, while surveying a state society, I was very impressed with the brilliance and thoroughness of a form until I realized it was one I had sent them a couple of years before – with no changes except for the name of the state!

Horizontal mentoring is a powerful force in our personal interactions with colleagues as we teach and learn from each other. When Frances Maitland took over as the exec of the Alliance, it was undergoing great membership growth. From a small gathering administered out of the hip pocket of Bill Felch, it was rapidly becoming one of the major CME organizations with many hundreds of members. A loosely organized Council directed ACME (as it was known then) with the assistance of Fran. This is now your Board of Directors. The Council members were a widely disparate lot – very out spoken and lively, with opinions on everything – but also with lots of good CME experience from many different angles. This was our strength. With Fran’s gentle guidance to break up the fights, we soon realized we really didn’t know where we were going or how to establish policies and procedures to get on track. The highly overpaid facilitators hired to guide us were useless, except for plastering the walls with endless flip charts full of unintelligible scrawlings. Gradually, on our own, we learned so much about each other: what it meant to be a CME’r in a medical school, a pharmaceutical company, a managed care group, a specialty society, a professional meeting planner, someone in Canadian CME, and all the other interests of the Alliance. From this evolved mutual respect and the necessary understanding to improve the mission and organization of the Alliance – it was horizontal mentoring at its best.

Now let’s go into an area not as frequently examined – vertical mentoring. This involves teaching, when necessary, your own higher-ups in the CME system. My most vivid personal example of this type of mentoring involved a frantic phone call from Frances when I was serving as chair of the CRR in the mid 90’s. “George – you and I and Steve Jay (then chairman of the ACCME Council) have to go to Rockville MD right away to meet with officials of the FDA. They really don’t understand the role of the states in the enforcement of the new Standards for Commercial Support. They may not be willing to recognize this role or that of the intra-state CME providers and with their control of the pharmaceutical companies providing CME financial support to local activities, — they could cut this off!” So in a few frantic days we were all in their offices doing some quick vertical mentoring to educate the FDA on the vital role of the states in the CME process and to show them how they were indeed enforcing the Standards for Commercial Support. It was the beginning of a long horizontal mentoring relationship; understanding each of our roles and responsibilities in ethical support of CME by industry. As you currently know, that is still a subject of interest.

Wearing the hat of an early ACCME surveyor for Frances in 1982 I did the initial survey of the Annenberg Educational Center. I asked her what form we should use for the report. “There isn’t any” she replied. “Just write us a letter on your findings and recommendations.” From these first

efforts and those of others, the extremely elaborate system evolved that we have today. So, much of the policies/procedures forms, etc. developed from the feedback of vertical mentors to the CME big-shots who made the final decisions.

I loved being a vertical mentor “educating” the power structure on needed improvements. For 21 years I helped vertically mentor the AMA, the ACCME, and every other group on the fact that the real action in CME in terms of number of participants, credit hours offered, and activities has always been at the intra-state level. Sometimes Murray Kopelow didn’t exactly use the label “vertical mentor” to describe me – but we had a lot of fun together. It may be hard to do this some times, but we shouldn’t shirk our vertical mentoring responsibilities. A personal tip on this – diplomacy is really needed if you want to achieve your goal here of vertically educating a CME superior on some aspect of CME or maybe, getting something changed. My favorite definition of diplomacy is the ability to tell someone to go to hell and making him look forward to the journey. This is particularly helpful when dealing with big medical egos.

One final gentle vertical example involving Alabama and the Alliance — when the role of hospital libraries changed in the 70’s from maintaining large collections of books and periodicals to accessing medical information on the computer. Our Alabama medical librarians volunteered to present a program to help all our state CME’s do this. Their outstanding efforts produced a notebook reference book so good, that Bruce Bellande got permission to reproduce it as “Access to Medical Informatics for CME’ – now a reference available for all Alliance members. Vertical mentors helping horizontal colleagues at the state and national level.

Let me summarize multidimensional mentoring:

1. Whether we realize it or not, we all perform mentoring roles in our CME responsibilities. It is one of the “Essentials” of our job and lots of fun as well.
2. These mentoring roles vary with the situation. Some times the interactions will be a veteran to a rookie CME’r, often it is colleague to colleague; it can also be a subordinate to a higher CME authority; i.e., mentoring can be vertical, downward, horizontal or a combination.
3. The same person may function as a mentor or mentee in all these different directions depending on the situation. It is not a static role. Labeling the direction of the mentoring is not really important – it’s the concept of multidimensional mentoring that is crucial.
4. Mentoring can be done in many ways: Personal discussion and interaction, in writing, speeches, and all forms of media. There are no limits to format.
5. The ultimate purpose of mentoring is to teach, guide, inspire, advise or whatever is needed, in whatever format is necessary to help a CME colleague.

It is an attitude toward your work and your colleagues.

Today we honor Frances Maitland in this lecture, a lady who epitomizes this broader concept of mentoring. Up until today, this lecture was given in a special program for new members of the Alliance with much helpful information offered on establishing meaningful mentor relationships. I am pleased that it has been moved to a wider gathering of the whole Alliance membership because mentoring relates to everyone in this room.

When I asked you to raise your hands to indicate if you had been a CME mentor, some responded – but certainly not the majority. I hope that if you were asked again, many more would raise their hands. Even the recently hired medical staff secretary just assigned CME duties, and sent to this Alliance meeting to learn the ropes is a fledgling mentor who will learn things to take home to teach her docs and other staffers about CME.

This is the memorial program from May 2, 1999 when many of us here gathered at the Newberry

Library in Chicago to celebrate the past life of Frances Maitland. We talked with her family about what a special influence she had on our lives. We talked amongst ourselves how she taught and inspired us and so many others for the betterment of CME, and ultimately the improvement of patient care. Her leadership extended in all directions among people at every level of CME. It was mentorship in the best sense. In fact, I would say our Alliance for CME is really organized as a giant mentor with almost all its materials, meetings, and activities designed to teach and assist fellow members.

I wish all of you CME mentors the very best in your important work.