Continuing Medical Education in Europe: OR EVOLUTION OR REVOLUTION?

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Continuing Medical Education in Europe: Evolution or Revolution?

Introduction and Statement of Need

ERIC-JEAN DESBOIS

When we first initiated the writing of this White Paper, our intention was to develop a clear picture of the current CME environment and the objective was to create awareness of it by elaborating on the driving forces and barriers posed to the professional healthcare community. Over time, it has become clear that recognition of the importance of CME from our primary audience is a “critical factor for success”, as stated by Thomas Kellner, one of the authors of this work. Therefore, in an effort to provide you with the most up-to-date information and expert insights, we have the privilege of offering you, by means of this publication, an in-depth look at CME in Europe for 2010!

Since “effective patient care depends on well functioning teams of healthcare professionals”, we have favoured an interdisciplinary approach in this publication by asking different healthcare professionals to share their viewpoint in a cross-pollination approach. As mentioned by Hervé Maisonneuve (see Chapter 4), “healthcare professionals and industries are partners and must cooperate, aiming for a win-win situation”.

As you know, CME has been well-designed and implemented in the United States since the late 1960’s. However, since the development of CME in Europe has not been uniform leading to considerable disparity in approach and practice, the focus of this White Paper is primarily on European CME. A number of these discrepancies will be addressed in Chapter 1, authored by Helios Pardell and Alfonso Negri.

There is a pressing need for more research in the field of evaluation methods and measures, especially measurement of changes in practice performance, and some specific techniques such as cost-benefit analysis. Workable models allow the examination of processes involved in translating knowledge into practice, lifelong learning, and the factors impacting the behavior of healthcare providers. Models would also facilitate examination of disparities, such as learning, behavior, effectiveness and function within a team.

What are the challenges to improving performance and healthcare outcomes? You will find out by reading the answer to this burning question under the sub-heading, “The Impact of CME on Public Healthcare Economy” (see Chapter 2, by Thomas Kellner).

In times of budget constraints and evaluations where the need to assess the input of each initiative and process in healthcare has arisen, we might ask at the end of the day, “what is the added value of CME?” Bernard Maillet proposes an answer in Chapter 3 entitled, “The Importance, Structuring and Harmonization of CME”. Dr. Maillet also describes the role, objectives and structure of the UEMS, in alignment with CME and with EU country requirements.

You may notice that one important topic has not been addressed in this White Paper, namely online education. This has become increasingly important, as demand from worldwide healthcare providers to access basic and clinical knowledge through the internet is drastically increasing. This key trend in continuing medical education has even been emphasized by the recent and exponential development of mobile internet. In Europe, this has been well anticipated by the UEMS which began delivering CME credits for online educational activities in 2009. Considering the importance of this new phenomenon, we decided not to cover the topic here but rather to do so in our next White Paper which will be published later this year.

So what is in store for CME in 2010 and beyond? The closing statement and interactive section, developed by Thomas Kellner, will provide several thought-provoking points of action entitled, “10 Steps to Evolve in CME in Europe in 2010.” Your comments will be more than welcome.

In these times of uncertainty, one thing we are sure of is that “the show must go on” as stated by Hervé Maisonneuve in his contribution. We deliberately decided to entitle this White Paper with a question: Continuing Medical Education in Europe: Evolution or Revolution? I warmly encourage you to read this White Paper and decide for yourself!
CURRENT CLIMATE AND OPPORTUNITIES IN EUROPE

PAREDÉLL, HELIOS(*)
NEGRI, ALFONSO*
I. Situation of CME in European Countries

The European Union of Medical Specialists (UEMS) has developed into the most representative European Medical Organization of medical specialists. UEMS follows the structure and facilitation of accreditation of CME/CPD activities to individual medical specialists throughout Europe with the European Accreditation Council for CME (EACCME). Through this approach, UEMS is able to provide Europe with a coordinated system to facilitate such activity, and at the same time, avoid interfering with the responsibility of national organizations.

The development of CME/CPD national structures has increased exponentially and should be acknowledged in order to appreciate the rapid change in different Member States. Moreover, the need for a formal record and recognition of a specialist’s commitment to the maintenance of knowledge, skills and expertise continues to develop as a requirement in most Member States.

Please see pages 6 - 11 for a comprehensive update on the CME/CPD situation in European Countries to date.
### CME/CPD Situation in European Countries to Date

<table>
<thead>
<tr>
<th>Country</th>
<th>CME Requirement</th>
<th>Accrediting Authority</th>
<th>Re-validation</th>
<th>Re-Certification</th>
<th>Relicensing</th>
<th>Incentives</th>
<th>Sanctions</th>
<th>EACCME Reciprocity</th>
<th>Distance Learning</th>
<th>Sponsored CME/CPD Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Mandatory</td>
<td>Austrian Medical Chamber and Academy of Physicians. Providers can be certified.</td>
<td>X</td>
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<tr>
<td>Belgium</td>
<td>Mandatory</td>
<td>State Insurance System (INAMI/RIZIV) with profession, universities, scientific organizations and Insurance Companies</td>
<td>X</td>
<td>X</td>
<td>√</td>
<td>X</td>
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<td>Bulgaria</td>
<td>Voluntary</td>
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<tr>
<td>Czech Republic</td>
<td>Mandatory</td>
<td>Medical Chamber is National Accreditation Authority</td>
<td>X</td>
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<td>X First 6 years</td>
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<tr>
<td>Denmark</td>
<td>Voluntary</td>
<td>Danish Medical Association with National Scientific Societies</td>
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<td>COUNTRY</td>
<td>CME REQUIREMENT</td>
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<td>RE-CERTIFICATION</td>
<td>RELICENSING</td>
<td>INCENTIVES</td>
<td>SANCTIONS</td>
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<td>SPONSORED CME/CPD ACTIVITIES</td>
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<tr>
<td>FINLAND</td>
<td>• Voluntary &lt;br&gt;• 150 credits 2 weeks each year</td>
<td>Accreditation system for hospitals, GPs and private doctors by the Ministry of Health</td>
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<tr>
<td>FRANCE</td>
<td>• 'Mandatory' but still voluntary in practice &lt;br&gt;• Recommended 250 credits over 5-year period</td>
<td>Accreditation system for hospitals, GPs and private doctors by the Ministry of Health</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>CME frozen awaiting new guidelines</td>
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<tr>
<td>GERMANY</td>
<td>• Mandatory in 16 States &lt;br&gt;• 250 credits per 5-year cycle (50 per year)</td>
<td>Scientific Societies, Medical Schools and NHS Hospitals</td>
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<td>Restricted</td>
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<tr>
<td>GREECE</td>
<td>• Panhellenic system. &lt;br&gt;• Mandatory for MDs on NHS System. &lt;br&gt;• Voluntary for MDs not in NHS System</td>
<td>Scientific Societies, Medical Schools and NHS Hospitals</td>
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<tr>
<td>HUNGARY</td>
<td>• Mandatory &lt;br&gt;• 250 credit point in 5 years. &lt;br&gt;• 30,000 licenses have been renewed with 200 physicians suspended</td>
<td>Medical Chamber is National Accreditation Authority</td>
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<td>RELICENSING</td>
<td>INCENTIVES</td>
<td>SANCTIONS</td>
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<td>IRELAND</td>
<td>• Mandatory • 250 points over 5 years</td>
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<td>National Committee of the Ministry of Public Health and Regional Boards</td>
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<tr>
<td>ITALY</td>
<td>• Mandatory by law since 2002 • 50 credits per year (3-year cycle) • 2010 beginning of Provider's accreditation, first with Distance Learning, then live events</td>
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<td>LUXEMBOURG</td>
<td>• Voluntary</td>
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<tr>
<td>THE NETHERLANDS</td>
<td>• Mandatory requirement for re-certification • 40 credits per year (5-year cycle)</td>
<td>34 recognized specialties in the Accreditation Consultation Body. Professional societies accrediting through the EACCME</td>
<td>X</td>
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<tr>
<td>NORWAY</td>
<td>• Voluntary</td>
<td>Mandatory recertification every 5 years</td>
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<td>20% of the fees for GPs. No incentives for specialists yet</td>
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<td>COUNTRY</td>
<td>CME REQUIREMENT</td>
<td>ACCREDITING AUTHORITY</td>
<td>RE-VALIDATION</td>
<td>RE-CERTIFICATION</td>
<td>RELICENSING</td>
<td>INCENTIVES</td>
<td>SANCTIONS</td>
<td>EACCME RECIPROCITY</td>
<td>DISTANCE LEARNING</td>
<td>SPONSORED CME/ CPD ACTIVITIES</td>
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<td>PORTUGAL</td>
<td>• Voluntary</td>
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<td>• No system of credits</td>
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<tr>
<td>ROMANIA</td>
<td>• Mandatory</td>
<td>Romanian College of Physicians has jurisdiction and supervision of CME/CPD, and license to practice</td>
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<td>• 200 credits in 5 years</td>
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<td>SLOVAKIA</td>
<td>• Mandatory</td>
<td>Medical Chamber, Universities and Scientific Societies</td>
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<td>• 200 credits in 5 years</td>
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<tr>
<td>SPAIN</td>
<td>• Voluntary</td>
<td>Autonomous Authorities, Ministry of Health, National Commission for Continuing Education, and SACCME</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>• No recommendations</td>
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<td>SWEDEN</td>
<td>• Voluntary</td>
<td>Specialist Societies</td>
<td>X</td>
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<td>• Recommended 10 days per year of external CME and ½ day per week for internal and personal CPD with the use of log book rather than credits</td>
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<td>COUNTRY</td>
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<td>RE-CERTIFICATION</td>
<td>RELICENSING</td>
<td>INCENTIVES</td>
<td>SANCTIONS</td>
<td>EACCME RECIPROCITY</td>
<td>DISTANCE LEARNING</td>
<td>SPONSORED CME/CPD ACTIVITIES</td>
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<tr>
<td>UNITED KINGDOM</td>
<td>• Mandatory&lt;br&gt;• Recommended 250 credits per 5-year cycle (50 per year)&lt;br&gt;• CPD rather than CME including not only CME but also CE in all aspects of MDs professional life, clinical and non-clinical.&lt;br&gt;• Clinical governance and “Good Medical Practice” form the basis for a Doctor’s annual appraisal.</td>
<td>National accreditation authority is the Academy of Medical Royal Colleges responsible for CPD division of revalidation into re-icensure. General Medical Council (GMC).</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>• Currently various sanctions through Royal Colleges&lt;br&gt;• Expected soon: threat of failed re-licensure or re-certification</td>
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<tr>
<td>BALTIC STATES (LITHUANIA, LATVIA, ESTONIA)</td>
<td>• Voluntary&lt;br&gt;• 200 Credits in 5 years</td>
<td>50% University&lt;br&gt;50% Ministry of Health&lt;br&gt;Specialty re-validation</td>
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<tr>
<td>POLAND</td>
<td>• Mandatory&lt;br&gt;• 200 credits in 5 years</td>
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<td>X</td>
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<td>• 1 year: 10% reduction in fees&lt;br&gt;• 2 years: 25% reduction in fees&lt;br&gt;• After 2 years: potential for withdrawal of license (hospital-based physicians are governed by their employer)</td>
<td>✓</td>
<td>✓</td>
<td>Restricted</td>
</tr>
<tr>
<td>SLOVENIA</td>
<td>• Mandatory&lt;br&gt;• 75 credits for re-certification and CPD</td>
<td>Medical Chamber of Slovenia</td>
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<td>Partial funding by authorization of Ministry</td>
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<td>SWITZERLAND</td>
<td>• Mandatory.&lt;br&gt;• Specialists can lose their membership of the Federation Medicorum Helveticorum, making it difficult to contract insurances and to practice&lt;br&gt;• 150 credits in 3 years</td>
<td>Well structured and regulated. Scientific Societies and Medical Association.</td>
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<td>CYPRUS</td>
<td>• Voluntary</td>
<td>Cyprus Medical Association with National Scientific Societies</td>
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<td></td>
<td></td>
<td></td>
<td>And National bodies of Europe/ USA/ Canada</td>
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<td>ICELAND</td>
<td>• Voluntary</td>
<td>National Committee of the Ministry of Public Health and Regional Boards</td>
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<td>MALTA</td>
<td>• Voluntary</td>
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<tr>
<td>CROATIA</td>
<td>• Mandatory</td>
<td>Societies/sections organize courses and meetings</td>
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<td>TURKEY</td>
<td>• Voluntary</td>
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European Societies and Boards:

EUROPEAN BOARD FOR ACCREDITATION IN CARDIOLOGY (EBAC)

UEMS Section of Cardiology supported by the European Society of Cardiology with 3 members from each body. It concentrates on quality control and facilitating of CME/CPD events with EACCME criteria which are very strict on commercial support.

ALSO OTHER EUROPEAN BOARDS SUCH AS:

Pneumology (EBAP), Oncology (FECS), Urology (EBU), Microbial & Infectious Diseases (ESMID), Vascular Surgery (EBVS), Neurol. Sciences (EFNS), Nuclear Medicine (EANM), Diabetes (EASD)

The situation in Europe is rapidly evolving. National Authorities are developing accreditation standards, quality control measures as well as disclosure and control of commercial funding processes. In addition, the reciprocity status now apparent between countries and accrediting systems underscores a clear evolution towards CPD in Europe.

II. Identifying and Addressing Discrepancies

As we have established in the previous section, great differences exist among European countries in relation to CME and CME accreditation. Those differences mainly arise from the following sources:

:: CME providers
:: CME funding
:: CME accreditation agencies
:: Utilization of CME credits
:: Re-validation systems
:: Role of medical associations and governments

Concerning CME provision, the role of governmental agencies, universities, professional associations, employers and private organizations is largely variable. Today, governments and public employers may be tempted to play too much an active role in CME. However, as time and experience have demonstrated, it is the course of wisdom to leave this responsibility mainly in the hands of medical associations thereby promoting the needed balance between CME as an ethic-professional duty of
physicians and CME as a responsibility of employers in the current labor framework in which most physicians are employees of public and private health care organizations.

This strongly correlates to the CME funding domain, wherein apart from the role of the aforementioned agents, the intervention of commercial sponsors is relevant.

_In this case, a clear regulation of conflicts of interests and commercial sponsorship should be stated at a European level,_

allowing member states to adapt individually to local conditions.

National CME accreditation agencies are scarce. In several European countries, different accreditation systems exist. What is needed in this respect is the fostering of creation of national CME accreditation agencies and the promotion of a harmonization process at a European level with the EACCME serving as a CME clearing house.

The role of medical associations and governments is complementary but very often conflictive. The formers must assume that CME is their main responsibility in the way of assuring the maintenance of competence of their members. Governments should avoid the temptation of being too interventionist in the context of the European welfare states, bearing in mind the advantages of a clear co-regulation system of the medical profession.

In relation to the utilization of CME credits, they are currently used in some countries as incentives for physicians’ salaries and fees. This is better than the attempts of several governments to implement CME mandatory by law which, in turn, very often lacks its adequate enforcement. Bearing in mind new developments in re-validation, i.e. re-licensure and re-certification, it is recommended that CME credits be utilized in a proper way in the larger context of Continuing Professional Development.
III. Impact on Patient Outcomes

It is assumed that the quality of patient care is profoundly affected by the lifelong updated competence and performance of individual health professionals.

CME is mainly aimed at maintaining and improving physicians’ knowledge, skills and behaviors throughout their careers in order to provide safe, effective, and high quality healthcare. The main objective of CME accreditation is, in turn, to promote and guarantee the quality of CME programs.

Therefore, it is understandable that CME and CME accreditation systems definitely influence the outcomes in terms of patient care. This should be clearly understood by both governments and medical associations in order to assume their own responsibilities of providing the best healthcare to the population. To attain this objective, they, jointly with the other involved agents, should devote the needed efforts to assure the provision of high quality CME programs through accreditation systems.
THE IMPACT OF CME ON PUBLIC HEALTH ECONOMY

KELLNER, THOMAS*; POSEL, PETER
After many European countries have invented mandatory accreditation systems, CME credits were expected to safeguard the license, counted by learning hours. Post questionnaires were designed to measure achieved learning objectives.

Now, the preferences of doctors attending CME programs are changing from personal interaction to online media. This trend raises e-CME programs to a higher level of attraction.

Organizations setting standards for CME require educational programs that produce “real world” results based on measurable changes in providing health care. CME program managers need to shift their attention from what is being taught to what is being learned. Credits should only be used as a “CME currency”. Models giving financial incentives for defined quality attributes linked to performance improvements are arising.

*COI: Peter Posel - Received educational grants from MSD, Essex Pharma.
Thomas Kellner - Full time employee of MSD (Pharmaceutical Industry)
Actual Impact of CME on Public Health Economy

Continuing medical education in the health professions is in disarray. CME programs, as currently practiced, do not adequately focus on improving clinician performance and patient health outcomes. The emphasis is put on measuring acquired knowledge based on training results and hours instead of assessing competence and skills as a result of professional development. It can be assumed that the impact of CME on public health economy is too little.

CURRENT CME PROGRAMS:

:: Rely on a lecture format and count hours of learning
:: Have insufficient emphasis on individual learning
:: Do not promote inter-professional collaboration, feedback, teamwork, or efforts to improve systems of care.
:: Do not make adequate or creative use of Internet technology.

In 1995 Davies and colleagues published a review related to the effectiveness of education strategies designed to change physician performance and health care outcomes. Widely used CME delivery methods such as conferences and lectures have little direct impact on improving professional practice. More effective methods such as systematic practice-based interventions and outreach visits were seldom used by CME providers. These findings from 1995 were confirmed again in 2008.

A systematic review of articles between 1980 and 2005 conducted by Laura Petersen assessed the use of explicit financial incentives to improve health care quality. Seventeen eligible studies addressed the question of whether explicit financial incentives improve the quality of health care. Thirteen of 17 studies examined process-of-care quality measures, most of which were for preventive services. One of the two studies with incentives at the payment-system level found a positive effect on access to care, and one showed evidence of a negative effect on access to care for the sickest patients. No studies were found that assessed incentives for not providing care. Very little conclusions can be drawn. Incentives require careful design.
What are the challenges to improving performance and health care outcomes?

Today the health care community in Europe is focused mainly on measuring knowledge improvement. As a next step the determinants of competence and skills need to be established and measured. Given the complexity of assessing performance improvement and change in patient care, bridges need to be built to find pragmatic models becoming truly effective.

1) FOCUS ON CORE COMPETENCIES

Maintaining professional competence is a core responsibility of healthcare professionals, regardless of discipline, specialty or type of practice. Six core competencies have been described by the American Board of Medical Specialties:

1. Patient Care - compassionate, appropriate and effective treatment

2. Medical Knowledge- knowledge about established and evolving biomedical, clinical and cognate sciences and their application in patient care.

3. Interpersonal and Communication Skills - skills that result in effective information exchange and teaming with patients, their families and professional associates

4. Professionalism - commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.

5. Systems-based Practice - awareness of and responsibility to larger context and systems of healthcare, ability to call on system resources to provide optimal care in interdisciplinary settings.

6. Practice-based Learning and Improvement - Ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence and improve practice of medicine

2) DESIGN OF CME PROGRAMS

According to the “Updated Accreditation Criteria” the CME providers have to make their contribution to meet the needs of performance and outcome-oriented programs. Four steps need to be considered when designing CME programs:
1. **Analyze:** The overall objectives of the program are specified (Criterion 1), educational needs are based on professional performance gaps (Criterion 2), and CME activities are designed with consideration to learning and setting attributes (Criteria 4 and 5).

2. **Design:** CME interventions must have a clear structure and are designed to achieve the program mission (Criterion 3), and CME content is developed in the context of desirable physician attributes (Criterion 6). CME activities are based on practice-based needs.

3. **Develop/Implement:** Content is developed and delivered independently of the influence of personal financial and commercial interests (Criteria 7, 8, 9, and 10).

4. **Evaluate:** Changes in learners are measured (Criterion 11), the effectiveness of the overall program is measured (Criterion 12), and the overall program is improved (Criteria 13, 14, and 15). Measurement includes non-educational criteria (e.g. patient feedback).

### 3) INTERDISCIPLINARY LEARNING IN DAILY PRACTICE

Effective patient care depends on well functioning teams of healthcare professionals. Therefore, CME must address the special learning needs of collaborating teams. Quality improvement efforts and CME activities overlap and are ideally mutually reinforcing. An objective and neutral assessment of clinical management options is precisely the basis for what is needed in continuing education.  

New concepts using various learning formats in a structured combination address team collaboration and individual performance: interactive patient cases combined with lectures and virtual classroom discussions. In a blind control study setting this new approach promises significant results, superior to classic learning models.

The goal is closing the gaps between scientific evidence and applied practice, between specialists and family doctors. A set of principles that should guide continuing medical education have been identified:

:: Integrate continuing education into daily clinical practice.
:: Base continuing education on the strongest available evidence for practice.
:: Emphasize flexibility and easy accessibility for clinicians.
:: Stress innovation and evaluation of new educational methods.
:: Address needs of clinicians across a wide spectrum, from specialists in academic health centers to rural solo practitioners.
:: Support inter-professional collaboration.
4) FINANCIAL INCENTIVES TO TRIGGER THE LEARNING ALERTNESS

Physicians have learned that evidence is not the only factor that impacts clinical decision making. A balance is needed between encouraging doctors to exercise individual professional judgement and paying them for carrying out specific tasks. Linking tasks to the receipt of money means that money rather than medical judgement drives practice.

Doran et al. describe the initial operation and effect of a British policy (adopted in April 2004) that bases a substantial portion of salary payments to general practitioners on their success in meeting 146 criteria for high-quality performance, each of which is tied to a variable number of points indicating greater changes in professional practice than previous research indicates. Other studies demonstrated that documentation, rather than actual use of the preventive service, in association with a financial incentive improved outcomes significantly.

The underlying goal of incorporating financial incentives for quality into physicians’ payments is not simply to reward “good” physicians or punish “bad” ones. The goal is to change the status quo by stimulating both immediate and long-term improvements in performance. The best process-of-care measures are those for which evidence shows that better performance leads to better outcomes. A combined approach capitalizes on the advantages and complementary nature of both types of measures.

The size of the bonus also seems to be important. Possible explanations for the lack of effect or small effect in some studies may include the small size of the bonus. One qualitative study suggested that a bonus of at least 5% of a physician’s capitation income may influence behaviour.

“End-of-year” compensation may not influence physician behaviour as much as a concurrent fee or intermittent bonus. This is because lack of awareness of the intervention and infrequent performance feedback seem to be substantial potential barriers to incentive effectiveness.

It is important to note that financial incentives and the health care payment system have an important influence on the provision of quality. It is a challenge in getting the right mix of criteria for quality. Incentives based on a handful of measures of quality may encourage physicians to focus their efforts on improving quality in the areas targeted by the programs, neglecting other important aspects of care. In contrast, incentives based on too many measures may overwhelm physician practices.
Conclusions

The efforts to redesign the structure, the content and formats of future CME programs need to be expanded substantially. CME providers have to make their contribution to substantially close the gap between theory and applied practice, between learning and behaviour. Updated and harmonized accreditation criteria will better position the CME enterprise to meet the professional development needs of physicians in the 21st Century.

*Information technology and the internet are enablers for practice-based learning and collaboration, they address individual learning needs by various content formats and can be accessed when and where needed (point of care).*

Financial incentives and the health care payment system have an important, although not exclusive, influence on the provision of quality.

Rigorous research, including randomized, controlled trials and observational studies with concurrent control groups, is needed to guide implementation.

As a result, learners participating in CPD activities will demonstrate changes in competence and skills, improvements in performance-in-practice and improved patient outcomes that can demonstrate the impact of CME in public health economy.

References


2 E. Borman; The Accreditation of e-CME and e-CPD by the EACCME. UEMS 2008 (filed for publication)

3 Paul C. Hébert, MD MHSc; The need for an Institute of Continuing Health Education. CMAJ (2008) March editorial


5 Laura A. Petersen, MD, MPH; LeChauncy D. Woodard, MD, MPH; Tracy Urech, BA; Christina Daw, MPH; and Supicha Sookanan, MPH; Does Pay-for-Performance Improve the Quality of Health Care? JAMA 2006 Vol.145, 265-272


8 Accreditation Council for Continuing Medical education (ACCME). CME as a Bridge to


11 Barnes B. Private; Communication based on presentation at CME Summit. Council of Medical Specialty Societies. November 2007

12 Wald DS; Problems with performance related pay in primary care. BMJ 2007;335:523


FUNDING MODELS OF CME AND CPD IN EUROPE

KELLNER, THOMAS*
Quality standards, codes of conducts and policies addressing various aspects of CME have been defined by medical societies, physician chambers, universities and CME related institutions. These standards do not necessarily foresee recommendations for funding models other then the demand for exclusion of commercial bias by the underlying sponsorship model. Industry is the main sponsor of CME in Europe. A future funding model giving attention to the required volume and concrete recommendations for funding sources needs to be defined. There is the opportunity for building an evidence-based CME model that is underlying controlled standards, but is not restrictive in sponsorship. A well managed balance between payer and industry funding might become a realistic model to finance European CME in the future.

A recent international Web-based survey of 806 of the 2200 members of the Association for Medical Education in Europe (37%) focused on the perceived needs of medical educators from 76 countries. Funding (36%) has been identified as one of the key challenges.

*COI: Thomas Kellner – Full time employee of MSD (Pharmaceutical Industry)
Assessment of funding needs

It is required to estimate funding needs with regards to all processes related to the provision of professional CME by recognizing status quo, efficiency, individual learning behavior, impact and reducing commercial bias. This includes all steps related to project management such as planning, production, execution and outcome measurement. For presence meetings, travel costs can become a dominating factor requiring almost half of the budget.

TABLE 1
STEPS IN THE CME CREATION AND EXECUTION PROCESS REQUIRING FUNDING

<table>
<thead>
<tr>
<th>PLANNING</th>
<th>PRODUCTION</th>
<th>EXECUTION</th>
<th>OUTCOME MEASUREMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coaching of CME personnel</td>
<td>Content development</td>
<td>Locations</td>
<td>Logistics</td>
</tr>
<tr>
<td>Needs assessment</td>
<td>Desktop publishing</td>
<td>Travel and housing</td>
<td>Statistical Analysis</td>
</tr>
<tr>
<td>Recruitment of faculty</td>
<td>Reviewers</td>
<td>Speakers</td>
<td>Honoraria</td>
</tr>
<tr>
<td>Hiring costs</td>
<td>Technical infrastructure</td>
<td>Logistics</td>
<td>Evaluation</td>
</tr>
<tr>
<td>Resource costs</td>
<td>Enduring materials</td>
<td>Administrative fees</td>
<td>(Publication)</td>
</tr>
<tr>
<td>Conception costs</td>
<td>Speaker training</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Media</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Production costs</td>
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<td></td>
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</tbody>
</table>

Funding Sources

Though a variety of funding sources are available, CME funding is mainly dependent on industry sponsorship. For Europe, a transparent data model based on an in-depth analysis and comparison of country funding models and volumes has not been published yet. Based on estimates with representative data from the big markets in Europe (France, Italy, Germany, Spain, and UK) about 50% of the funding volume is based on industry sponsorship. Almost half of the funding goes into travel and housing for meetings and congresses.

It is important to assess and investigate the real volume of existing funds and to carefully identify and eliminate the sources of potential bias related to the funding model instead of challenging the funding model itself as a first step. Though industry sponsorship is currently under pressure due to commercial bias, alternate funding sources are not necessarily free of bias or may not deliver the appropriate volumes of funding with a negative impact on quality. Several authors have doubts that the current offers of programs and quality could be maintained without industry sponsorship. With
regard to self-pay there are limitations in the capability and willingness of physicians to fund education on their own and a lack of volume to provide significant capabilities by other funding sources (e.g. patients, societies).

**TABLE 2**
**FUNDING SOURCES & POTENTIAL BIAS**

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>POTENTIAL BIAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Funds</td>
<td>Access to specific treatments</td>
</tr>
<tr>
<td>Insurance systems</td>
<td>Healthcare cost containment</td>
</tr>
<tr>
<td>Government</td>
<td>Healthcare cost containment</td>
</tr>
<tr>
<td>Industry</td>
<td>Commercial interest</td>
</tr>
<tr>
<td>Taxation</td>
<td>Healthcare cost containment</td>
</tr>
<tr>
<td>Societies</td>
<td>Industry sponsorship, membership</td>
</tr>
<tr>
<td>Publishers</td>
<td>Funding Model</td>
</tr>
<tr>
<td>Self-Pay including co-payments</td>
<td>Industry sponsorship</td>
</tr>
</tbody>
</table>

Other funding sources like government or taxation either imply more than modest mechanisms of additional bureaucracy or sources like private funds struggle in achieving critical volumes and do not qualify as an alternate model. Though the demand of excluding commercial organizations from funding CME is stated in many current comments, investigations and editorials, it has neither been demonstrated that enough funding volume can be originated without commercial sponsors nor that the standards of controlling CME are controlled enough to ensure appropriate CME. Some studies investigating risk stratification tools to identify inappropriate influence demonstrate positive results in reducing bias. The College of Family Physicians in Canada defined standards reducing inappropriate bias to a high degree.

**Funding Period and Cost Effectiveness**

The period requiring funding of postgraduate CME starts with the academic degree and ends with resigning as a healthcare professional.

*Funding needs to favor the maintenance of knowledge, competence, and skills necessary to provide high quality care.*
Given the limitations of working hours and funds, CME models need to be cost effective. This implicates quality management and control, outcome measurement and the use of alternate learning formats like new media. Additive motivation factors as additional income via pay per performance programs may demonstrate positive effects, but also need to be further investigated. The reduction of face-to-face meetings in the benefit of e-learning and alternate formats can free up significant funds by reducing efforts for travel and housing, which often counts for 50% of the budget.

**Commercial Sponsorship**

The influence of commercial bias dominates the CME debate within and outside Europe. Many factors with regard to commercial sponsorship have been investigated and resulted in a positive correlation. Indeed there is a commercial necessity for individual companies to acknowledge that they carefully evaluate the market impact of expenditures and support only those demonstrating a positive impact on their commercial model. Many authors conclude that commercial sponsorship needs to be restricted or reduced.

A new trend can be recognized in Pharma seeking for models in compliance with high CME standards intending to maintain independency and high standards of quality whilst minimizing the level of influence of the sponsor. Whilst the weight in the public debate is given to the negative influence of commercial sponsors, the opposite side of a too restrictive environment in preventing access to new treatment options and medications by lack of “promotion” is uninvestigated and a major risk. A recently published Meta analysis concluded that there might currently be no evidence to refuse or support the hypothesis that commercially-supported CME activities are biased.

**Discussion**

A future funding model for CME in Europe reduces inappropriate bias, identifies conflict of interest sufficiently and assures education recognizing high quality standards based on improved patient outcomes by keeping healthcare expenses under control. The controversy between best quality in patient care and financially affordable quality in the sense of cost containment is a separate debate that will not be addressed here.

Transparency towards the sponsorship of CME needs to be given. The terms and purposes of any commercial support to CME providers and educational partners should be stated in written agreements that should be...
endorsed to any published CME program as similarly stated in the standards for Commercial Support by the ACCME. Based on the analysis of CME providers in the US, the levels of compliance achieved towards bias and quality is rather high, but it varies a lot between the parties being allowed to provide education to HCPs. This can be stated as a limitation of the current system requiring a higher level of control and standards.

Funding volume is poorly assessed in Europe. The focus is on development and delivery including travel, less attention is given to primary needs assessment, effective adult learning formats, outcome measurement based on representative evaluations and training of CME resources. It will require an increase in funding based on achieving higher quality in CME rather than restrictions without proven alternatives. There is a gap between funding volume and funding needs that can be closed by making CME more attractive to sponsors. Factors encouraging sponsorship without violating CME principles should be further investigated.

In Europe’s healthcare market, significant volumes for financing CME can be made available by primarily two parties: industry and insurers/payers. A commercial interest in funding CME might be stated for both, hence they are acting as “opponents”; access to new medicine versus cost containment. If based on appropriate and controlled standards this might result in a healthy balance.

To achieve better funding volumes and to avoid exclusions of funding parties, a more effective definition of the interaction of sponsors with providers is required, similarly as stated in the AAMC taskforce report. An alternative to be further investigated is a control function by an independent third party. Such a party could be a publicly funded national and regional institution like the EACCME. Such a control instance would perform provider or program accreditation including the definition of guidelines and auditing.

**Encouraging sponsors to contribute to delivering independent, fair balanced and outcome-oriented CME results in a benefit towards the overall funding volume.**

This favors a CME market measured on quality that underlies the dynamics and evolution of a free market, giving individual physicians the choice of multiple learning programs recognizing their needs and skills. This is a unique opportunity for Europe.
References

1 Medical Education after the Flexner Report; NEJM, Volume 356:90-91, To the editor
2 H. Maisonneuve; Current status of CME funding, presented at the 33rd Alliance for CME annual conference, January 2008
3 G. Druck, H.P. Kuhn, U. Haller; Is Continuous Medical Education under Suspcion of Corruption? Contribution to the Discussion by the Committee for Quality Preservation of the Swiss Society for Gynecology and Obstetrics; Gynäkologische Geburts hilfliche Rundschau, 2003; 43:111-117
4 Iskowitz M; CME's new order; Medical Marketing & Media; August 2006: 37-47
5 R. Van Harrison; The uncertain future of continuing medical education: commercialism and shifts in funding Contin Educ Health Prof 2003; 23(4):198-209
6 Daniel J. Carlat; Commercial Support: The Last Gasp; Jul 1, 2008 accessed at www.meetingsnet.com
7 Buchner B; Industry-sponsored medical education--in the quest for professional integrity and legal certainty; Eur J Health Law. 2007 Dec; 14(4):313-9
8 P. Biron, M. Plaisance, P. Lévesque; Pharmas-co-dependence exposed. Would it be time to say, "No thanks"? Can Fam Physician. 2007 October; 53(10): 1635–1637
10 Barbara E. Barnes; A risk stratification tool to assess commercial influences on continuing medical education; Journal of Continuing Education in the Health Professions, Volume 27 Issue 4, Pages 234 – 240
12 World Medical Association; Declaration of Rancho Mirage on Medical Education adopted by the 39th World Medical Assembly Madrid, Spain, October 1987 and rescinded at the WMA General Assembly, Pilanesberg, South Africa, 2006; PRINCIPLE VIII – Continuing Medical Education
14 Steinbrook; Financial Support of Continuing Medical Education; JAMA 2008; 299: 1060-1062
15 Brennan; Citing PhRMA Congress Conference Spring 2003; JAMA. 2006; 295: 429-433; June 8-9,2003; Washington, DC
16 Medical Meetings; Pfizer Cuts Off Funding for Medical Education Companies; Jul 2, 2008 10:51 AM; accessed at www.meetingsnet.com
17 PR Newswire; MSD signs partnership with BMJ group; Jun 17, 2008; accessed at http://www.highbeam.com/doc/1G1-180213953.html
18 Cervero RM, He J. The Relationship between Commercial Support and Bias in Continuing Medical Education Activities: A Review of the Literature. Accreditation Council for CME. June 2008; accessed at http://www.accme.org/dir_docs/doc_upload/aa6fccc3-aef4-40cb-99e6-4e0c8b23be_uploaddocument.pdf
19 ACCME; Standards of Commercial Support; 2007, accessed at www.accme.org
20 AAMC; Industry funding of medical education; June 2008, accessed at www.aamc.org/publications
IDENTIFYING CONFLICT OF INTEREST

A CLOSE RELATION BETWEEN MEDICAL RESEARCH AND MEDICAL EDUCATION

KLEINOEDER, DR. THOMAS; KELLNER, THOMAS*
The Discussion of Conflict of Interest (COI) attracted serious attention in medical literature in the 1980’s. These discussions were mainly focused on the area of medical research and addressed physicians, medical researchers and medical institutions.¹ The Concept of COI itself and the purposes of regulation are still inadequately analyzed and standards are often misunderstood.² With the upcoming efforts in systematic non-biased medical education the topic was intensively discussed in the last years in relation to Continuing Medical Education (CME) and Continuous Professional Development (CPD).

A profound COI-policy is an essential prerequisite for the future of medical education.³
Definition

The “Conflict of Interest” in medical practice has many aspects. Most definitions focus on the financial aspects. The topic is addressed in a general manner in the world-wide accepted ethical guidelines for research, the “Declaration of Helsinki”. Most scientific medical journals have COI policies that follow the principles from the International Committee of Journal Editors.

In the field of CME, the Accreditation Council for Continuing Medical Education (ACCME) in the US and the European Accreditation Council for Continuing Medical Education (EACCME) have published COI-policies. The overall focus of the definitions is to put the well-being of the patient in the centre and to exclude other influences on the content.

As a general definition COI can be defined as a set of conditions in which professional judgement concerning a primary interest such as patient welfare may be influenced by a secondary interest like a financial gain. The secondary interest is usually not illegitimate in itself. It may be a desirable part of professional practice. Only the relative weight in the context of medical education is problematic. The goal of any approach should be to prevent the secondary factors from dominating the primary interest that is mainly professional patient care in CME. Conflict of Interest can be seen as a divergence between individual/private and professional interests and COI is dependent on a concrete situation.

Identifying the “players” and their COI in CME

The discussion of COI focuses mainly on Authors or Speakers and their financial support. There are many more parties involved in COI with many kinds of conflicts. To establish a substantial COI-Policy in Medical Education all players and their conflicts must be handled.

PARTIES AND PLAYERS WITH A POTENTIAL CONFLICT OF INTEREST INCLUDE:

Physician (as Author, Speaker, Reviewer, Editor), Medical Institutions (Hospitals, Universities, Research Institutions), Health Authorities, Accrediting Bodies, Medical Associations, Medical Education and Communication Companies (MECC)/Facilitators, Press (Lay/Scientific), Industry and Sponsors, Health Insurance Companies.
POTENTIAL CONFLICTS OF INTEREST OF THE MENTIONED PARTIES CAN BE:

:: Financial support for research, CME courses, speakers or events in any way including research contracts, consulting, employment and stockholdership or ownership of a healthcare company

:: Intellectual conflicts: politics, personal rivalries, lust of power, institutional pressures, drive to secure tenure, desire for prizes, desire to please (peers), idiosyncratic

Impact on CME

Medical education should be an unbiased and evidence-based educational activity to teach physicians about patient care strategies. There is an obvious difference to marketing activity where the commercial aspect is the central point. Following the policy of ACCME, the interest in health and well being of the public is more important than any economic interest.”

That means that for medical education, some economic interests are in conflict with public interest. The “Global Corruption Report” addressed the topic in 2006.

COI causes a problem of integrity. The severity of a COI depends on the likelihood that professional judgment will be influenced and the seriousness of the harm that results from the influence.

Within the present CME-System, commercial sponsorship is involved in about 60 percent of all CME activities. The present funding model of CME is dependent on sponsorship. In all CME activities, money can motivate doctors to give biased information for medical practice, so criteria for critical judgment are necessary. With a look at the players one should conclude that all main players have some kind of financial interest in CME-Activities. So the main focus should be to exclude possible COI instead of restricting sponsorship.

It is necessary to set up a model that leads to transparency.

Present Situation in Europe

The growing role of governments or other authorities in regulating COI is in part a result of the failure of physicians and researchers to deal ad-
equately with the problem. In many European Countries CME Systems are in place. Most of the member countries of the European Union have CME Accreditation systems in place, whereas several of the overall 50 European countries do not have such systems established. That means that the Situation of CME/CPD regulations in Europe is very heterogeneous in regard to accreditation and as well as in regard to related national COI regulations.

The European Union of Medical Specialists (UEMS) established the European Accreditation Council for CME (EACCME) in 1999. The goal was to promote national structures that make credits exchangeable. In consequence, there must be a common understanding or policy for COI and Accreditation. But, until now the system is not what was intended and a common European COI policy seems to be far away.

**Strategies to Avoid COI**

Proposed standards sometimes give the impression that medical professionals are not able to handle COI and present unbiased scientific information. The main purpose of a strategy to avoid COI is to maintain the integrity of professional judgement. All rules must try to minimize the influence of the secondary interest. In addition the policy must be suitable to apply to all forms of CME from events to literature and from electronic media to future formats. Disclosure Forms and Questionnaires are a minimum prerequisite but they are not sufficient to exclude all kinds of potential COI.

The best way should be a model to manage all real or perceived COI through effective self-regulation. Patient care must be based on scientific evidence, and commercial interests should not determine the topics or contents of educational events.

**COI IDENTIFICATION MODELS MUST AT LEAST INCLUDE THE FOLLOWING ASPECTS:**

- Assure reviews of materials-based rules including a COI-Policy
- Exclude recommendations without scientific evidence
- Exclude bias in questions asked before or after a course/presentation
- Exclude recommendations preferring one specific product or harming other products
:: Assure balanced comments, mentioning harms/weaknesses and benefits/strength of a therapy

:: Assure balance of study results (positive & negative)

:: Assure conclusions in line with conclusions in the studies cited with given evidence

:: Assure recommendations consistent with evidence and guidelines.

:: Exclude commercial bias (promotional statements, brand names, product logos on handouts of assessment questionnaires)

To realize a model, a reviewing process for materials seems to be an established mechanism. A CME activity might be reviewable by colleagues or authorities, but these must be seen as independent and without COI itself. The review process must be based on a set of COI-Standards and must be followed by an audit-process.

A policy cannot cover all contingencies, but it is hardly a reason not to have one. ACCME has published their policy on how to manage conflicts of interest in relation to their Standards for Commercial Support. It can be taken as an advanced example for Europe. The main steps are titled: Avoid – Disclose – Manage. The Basel-Declaration of UEMS was an important step in that direction for European countries.

In summary there is a need for a mixture of methods to establish a substantial COI policy. The basis must be a widely accepted “Code of Ethics in CME” that has to be followed by a combination of measures that focus on the content and the delivery process in relation to the national models in the different countries.

COI in the future CME environment

COI identification in the context of CME requires a common understanding between countries, within countries and between specialties. There are proposals that become stricter and stricter such as prohibiting any input from sponsors for CME-Activities. They are more and more difficult to follow and run the risk of lowering the quality of CME-Events if commercial sponsors are banned before setting up alternate models. It will be difficult to give up any kind of sponsoring of educational events. On the other hand there are innovative proposals that can
lead to a fundamental change in the system like ideas of “Pay for Performance,” and new quality measures. All these proposals have to be judged carefully and put together to create a new model with rules for a COI policy instead of trying to ban only one player in the field of CME. It must be taken into consideration that the future health care model will have new players and new roles for the present players.

Conclusion

A system of quality Continuing Medical Education is a key success factor to the delivery of quality medical care in the future. It will never be possible to exclude COI completely, it is necessary to manage it in a way that is in best interest of the public and based on robust standards. Simply banning some players in the health care arena is not a solution. A harmonized European CME System seems to be out of reach in the near future, but a common ethical understanding and set of rules for COI would be a main step forward. A set of core principles can lead to a mechanism to identify the broad aspects of COI before the event in regard to content validity and credibility/face validity.

It could be beneficial to build or authorize an independent organizational infrastructure to handle, control and audit COI standards on a regional level.

References

3 AAMC. Industry Funding of Medical Education. 2008; https://services.aamc.org/Publications/index.cfm?fuseaction=Product.displayForm&prd_id=232&prv_id=281.
8 Relman AS. Defending professional independence: ACCME’s proposed new guidelines for commercial support of CME. JAMA. May 14 2003;289(18):2418-2420.
11 Spivey BE. Continuing medical education in the United States: why it needs reform and how we


22 Fletcher S. Pharma and CME: View from the US. BMJ. 2008;337:a1023.


THE IMPORTANCE, STRUCTURING & HARMONIZATION OF CME-CPD
Introduction

Accreditation in Europe is a developing matter in some countries, while in others, systems have been established for many years. In addition, the way accreditation is viewed by authorities is also very different.

While most countries within the European Union have similar objectives in developing structures for CME accreditation, methods of reaching that objective can vary greatly. Therefore, UEMS’ mission has been to harmonize the accreditation process in Europe as a whole.

The following topics will be addressed in this chapter:

:: History of the Union of European Medical Specialists (UEMS)
:: Accreditation
:: EACCME background and structure
:: Harmonization of the process
:: Future perspectives
History of UEMS

The UEMS was established in 1958, following the signing of the Treaty of Rome in 1957. In the Treaty of Rome, harmonization and mutual recognition of diplomas was anticipated. The objective of the UEMS has always been to bring together medical specialists of the member states and reach consensus on content and quality of medical specialist training and practice. The outcome of this process was meant to serve as the foundation for EU legislation.

The start was slow, but in the seventies the EU moved towards legal provisions in this matter. The Specialist Sections were established from 1962 onwards and the UEMS with its Sections was instrumental in the shaping of the “Doctors Directive” in 1975, which established the mutual recognition of medical diplomas between the member states of the EU.

The Nineties

The UEMS emphasis moved away from providing the EU with recommendations towards broadening the work on harmonization and improvement of content, quality of training and practice on the shop floor of medical specialists.

For this purpose European consensus documents were developed during the nineties concerning key-issues such as professional training, continuing education, quality assessment and tools like logbooks and visitation of training centres. The outcome of this process was embodied in the UEMS Charters. These Charters were presented to the professional authorities in the European countries as models and recommendations for national policy. Although the Charters do not have legal value, their influence upon national regulations has been considerable.

Present situation

The philosophy of all national professional medical organizations is that patient care is best served when quality and content of medical training and practice are the domain of the medical profession. In each country, the profession is defending this position. Unfortunately we are experiencing that this defense is becoming ever stronger. Governments, insurance companies and commercial interests are eager to take over the quality agenda.

A determined and continued effort of the profession is needed if the profes-
sion wants to maintain and improve quality in a proper way. In order to do this, unity of purpose and action is necessary. This requires balancing of professional and political views and interests.

**National level**

Unification of policy has to start at the national level. The professional societies in the specialties at the national level are doing a great job in quality improvement. But this has to be implemented at each level of medical practice, all the way from individual private practice to hospital management, training requirements, certification, validation, professional regulations and national legislation.

Close cooperation of the professional societies with the political national medical associations and societies is necessary to achieve implementation of quality policy in a proper way. Only with unity of purpose and policy can results be achieved.

Unfortunately, in many European countries this unity of purpose and policy is not that what it should be, and a greater effort on this issue is necessary. National professional organizations should be more aware of the significance of a strong European representation.

**European level**

The lack of national unity of policy reflects itself immediately in the representation of the medical profession on a European level. Too often, delegates of organizations of the same country are bringing opposing views into different European medical organizations.

**European medical organisations**

On the European scene, there is the UEMS with its UEMS Sections and European Boards, the European professional Societies in each specialty, but there are also the umbrella organizations of the national medical associations Comité Permanent of European doctors (CPME), and other independent medical organizations such as the European associations of junior doctors (PWG), hospital doctors (AEMH) and salaried doctors (FEMS). Basically each group started out as a lobbying group for its own interests, but progress in the unity of purpose and policy has been made. This process of confederation has to be pursued.
The Future

The UEMS with its Sections and Boards is by far the largest of all political European Medical Associations, and it has an extensive grass-root support. It has accomplished much, but more is needed. So far, each country is autonomous in health care matters, but European integration is gaining momentum. The profession must be ready to play its role in a future integrated European health care policy.

At a European level a more unified voice of the medical profession is needed, leaving intact the professional independence of sectoral groups like medical specialists, general practitioners, etc. Here the same unity as at the national level should be achieved.

Accreditation

CME/CPD is an important part of the medical practice today. When we look at the training to become a (specialist) doctor, it starts with undergraduate and graduate training at the University followed by Postgraduate Training that is done in cooperation with the Profession and the University (ideally).

In the past, this was the end of the process, but it is more than obvious that life-long learning must be pursued in order for a practitioner to maintain knowledge and skills. Here is where CME and CPD play an important role.

It started with Continuous Medical Education where mainly theoretical courses and congresses were organized.

Nowadays, this is completed by the improvement of communication, IT, managerial and social skills and is more concentrated on the practice of each individual practitioner and his or her needs.

The CME / CPD needs and the way it has to be organized is a duty of the National Accreditation Authority in each European Union Member State and can be National or Regional (or a combination of both).

The NAA has to define how many “credits” and which kind of credits are needed each year or each period of time.
It is more than obvious that one cannot gain all his or her credits by following only one means of CME / CPD, meaning that for instance not all credits may be earned by following Long Distance Learning Programs only.

Other means such as live events, enduring material, like CD-ROM’s, or articles also have a certain role to play in the whole picture of the CME / CPD of a (specialist) doctor.

It is clear that this remains a responsibility of each NAA.

The UEMS started the EACCME® in order to help the European Medical Specialist to have the credits he or she has earned by going to International Meetings approved by his or her NAA in order to avoid a duplication of the process.

For instance, when I, as a Pathologist go to a meeting organized by the British Division of the International Academy of Pathology and that has been approved for CME by the Royal College of Pathologists of the UK, why should the Belgian Accreditation Authority start the process of approval again?

This was the start of the EACCME® where we proposed a kind of clearing house where requests for European Accreditation could be received and reviewed.

History and political background of EACCME®

Continuing Medical Education (“CME”) and Continuing Professional Development (“CPD”) have always been one of the major key elements of the UEMS as it notably promotes the quality of care and the best level of training for medical specialists. This became concrete in 1993 when the “UEMS Charter on CME” was adopted. Since then, further work has been laid down in the field of CME and CPD and other declarations and position papers have been adopted such as the “Basel Declaration on CME” (2001) or “UEMS Declaration on the promotion of good medical care” (2004).

At the same time, many European countries have been taking steps towards mandatory CME, together with legal or professional re-certification or re-licensing, financial incentives or contracts with insurance companies and hospitals. Even though the UEMS defends voluntary CME, it was felt
appropriate to help European medical specialists in this respect. Therefore, in October 1999, the UEMS Council set up the European Accreditation Council for CME (“EACCME®”), with a view to:

:: Facilitating access to quality CME for European doctors;
:: Contributing to the quality of CME in Europe; and
:: Exchanging CME credits in Europe easily

The quality control of CME activities is a key element in this process. It was thus decided to operate in a decentralised way by using the expertise of existing European and national professional bodies involved in accreditation.

The everyday management of European accreditation by the EACCME® provides this link between European and national levels. One has to remember the political necessity to comply with the political authority of national professional regulatory bodies, as these bodies are responsible for registering doctors’ CME-CPD and awarding licences to practice.

**EACCME® Structure**

The EACCME® was founded in 1999 as a separate entity from the UEMS even if though ruled by its Management Council. In the revised Statutes, the Executive Board proposed upgrading the EACCME® as one of the five genuine bodies of the UEMS in order to stress the importance of this body.

**THE EACCME® MANAGEMENT WOULD STILL REMAIN AS IT IS:**

:: The governing body is the UEMS Council, which is made up of representatives from national associations of each UEMS member country.

:: An Advisory Council provides recommendations with regard to the management of European accreditation. This body is made up of representatives from:

  - National professional CME authorities, including national CME accrediting bodies;
  - The UEMS, including its Sections and Boards;
  - Professional specialist organizations and societies.

This Advisory Council provides a full exchange of expert-knowledge and collaboration between the various partners involved in accreditation at a European level. The UEMS convenes a meeting of this committee each year as it is committed to the further evolvement of EACCME® proce-
dures in cooperation with the members of this advisory committee. The daily proceedings of the EACCME® are managed by UEMS Executives in its Brussels Secretariat.

Right from the start, it was clear that national professional regulatory bodies would approve a structure, such as the EACCME®, which would make CME credits in Europe exchangeable. The only condition was that these bodies would remain in charge of events in their own country and would have a major input in the process of EACCME®. This is a political reality. Moreover, it is expected that within a few years mandatory re-certification would apply in several countries. CME credits would then be the instrument used in this respect.

**Practical operation**

The EACCME® received its mandate from national regulatory bodies together with several distinct conditions.

National authorities are maintained. EACCME® does not become a supra-national body, but a link and clearing-house between national regulatory bodies.

The final word concerning accreditation of each activity remains the decision of the national regulatory body in the country where the activity takes place.

The Brussels administration should be as lean as possible. Quality assurance and determination of number of credits of separate CME activities would be decentralised, EACCME® relying upon the expertise of professional bodies in each specialty (such as the UEMS Sections and/or Boards and European Speciality Accreditation Boards). This aims to avoid duplication of quality assurance proceedings.

There would be no accreditation of commercially biased activities, internet activities and for the time being each activity should be judged separately. Thus, providers are not accredited for a series of activities stretching over several years.

Administrative expenses of the EACCME® are borne by the providers of activities applying for European accreditation. Expenses would be limited, avoiding duplication in Brussels of work already done by other accreditation bodies.
The recognition of EACCME® credits (ECMEC’s) is only guaranteed by national authorities within the framework of these conditions. The EACCME® strictly complies with this set and operates according to the procedure:

The accreditation process in Europe involves two partners; on the one hand the National Accreditation Authorities and on the other hand the UEMS Specialist Sections and/or Boards. The responsible National Authorities are determined according to the place where the meeting is organized and the involved Specialist Sections are determined based on the specialty that is most involved or to the target audience of the event.

Let us now look at how the process works in practice.

**Flowchart of the process**

1. **Provider**
2. **Request**
3. **> 3 months**
4. **UEMS - EACCME**
5. **N.A.A.**
6. **< 3 weeks**
7. **Sections**
8. **Evaluation**
9. **Evaluation**
10. **UEMS - EACCME**
11. **Certificate of Recognition**
12. **Provider**
The organizer of an event fills in the web based application form with all the relevant and needed documents.

Here the request form will be distributed by e-mail to the two partners.

The relevant UEMS Section and/or Board assess the scientific value of the CME activity. This evaluation strictly follows UEMS Quality criteria defined in D-9908.

The National Accreditation Authority will also grant the event and by doing so guarantee the value of the credits allocated to the activity.

Both partners are requested to give, in a well determined time scale, an approval or a refusal for accreditation, the number of credits being determined by UEMS – EACCME®.

Credit system

As the different National Accreditation Authorities apply different credit systems, European CME Credits (“ECMEC”) were introduced in order to harmonize the number of credits on the following basis:

1 ECMEC per hour.
3 ECMEC for half a day.
6 ECMEC for a full-day event.

National authorities can then convert these credits into national units, following the National rules. A conversion table will be established so that this conversion of ECMEC’s into National Credits is more transparent.

Evaluation of events

It is very difficult (if not impossible) to fully evaluate an event before it is held based on documents that are provided by the organizer. Therefore, future efforts will be concentrated on asking the organizers to perform an evaluation of the event amongst the participants. This evaluation should be kept quite brief since, in the end, an overly detailed evaluation would be problematic to analyze.

THE MAIN QUESTIONS COULD BE:
:: Was the event well organized?
:: Did I learn something from the event?
Will what I learned from the event change my practice?
Did I sense any bias?

The evaluation can be graded from “fully agree” to “fully disagree” by five steps for instance.

The principal aim of this evaluation is not to retrospectively throw away the allocated credits but rather help in the evaluation of the next meeting of the same kind organized by the same people.

The EACCME® is mostly involved in the evaluation of large international events that are recurring events so this will help in the process.

What’s the added value?

As shown, the added value of EACCME® lies in the link set up between the professional societies, the CME providers and the national regulatory bodies. Any change to this procedure would require the consensus of national regulatory bodies. Any deviation from this consensus would defeat the purpose of the EACCME®, and it would also mean the loss of the agreement with the American Medical Association concerning mutual recognition of EACCME® and AMA credits.

From the point of view of the event organizers, the added value lies in the international dimension that would be given to an event. More participants from abroad and also from the USA would be interested in attending their meetings.

The agreement with the American Medical Association has been renewed and is now valid from July 1st 2006 for a period of four years.

The long-term benefit is the link with the national regulatory bodies. These bodies are very keen on preserving their national authority in the awarding of credits to the doctors in their own countries. The EACCME® offers an institution in which they participate and have authority. In this way the profession facilitates exchange of CME credits in Europe in a similar way as postgraduate diplomas are mutually recognized according to European law.

In the end it is the National Accreditation Authorities together with the National Licensing Authorities that provides the license to practice.

The ultimate goal is to develop a system that makes life easier for our colleagues and to provide them with recognized quality CME with the guarantee that they can use their CME credits to meet national requirements.
Near future

Until now, UEMS-EACCME has only dealt with live events but the decision was taken by the UEMS Council to start the process of also including e-learning programs in the process.

This is a major step that needed to be considered as web-based learning is increasingly important and fills a gap as it is not always possible for doctors to attend meetings in distant places.

Since April 2009, e-learning has become part of the UEMS-EACCME evaluation and accreditation process but some practical issues still have to be formalized such as the number of credits to be allocated as well as the fee.

E-Learning encompasses recorded video, recorded audio, webcasting of live meetings, CD’s, DVD’s as well as material on PDA’s, but not printed material.

The criteria for evaluation of these activities will be similar to the ones in vigor for live events although some attention will be given to technical issues.

Next steps

Obviously, enduring material such as literature and other formats for learning will have to be considered in the future.

Fee

The UEMS – EACCME asks a fee for the processing of applications. This fee is based only on the number of participants and is a sliding scale. As we have two equal major partners in the European Accreditation, they also share their part of the fee.
THE ROLE OF THE PHARMACEUTICAL AND MEDICAL DEVICES INDUSTRY IN CONTINUING MEDICAL EDUCATION OF EUROPEAN PHYSICIANS

HERVÉ MAISONNEUVE, MD*
Transferring experiences from North America to Europe is difficult: it requires wisdom, time, and the recognition of social habits.

Industries work closely with physicians and health care professionals with the common goal of improving the quality of patient care, clinical performance and the patients’ health. Drugs and medical devices have brought major innovations to the medical community in the second half of the 20th century. Most of the disabling diseases in the developed world, except a few examples such as cancer and aging diseases have benefited from diagnostic and therapeutic progress. In fields such as cardiovascular, infectious diseases, gastroenterology, etc… many drugs have been made accessible to patients and physicians. Innovations result from the collaboration between industries and health care professionals.

Unsatisfactory health outcomes are still observed when drugs exist. This is due to many factors, such as the patients’ poor compliance, and the insufficient or delayed education of professionals. Most practicing physicians learn innovations after they have finished their medical school. Continuing medical education (CME) participates in decreasing the gap between scientific evidence and practices by improving knowledge and accelerating the implementation of new diagnostic and therapeutic strategies.

*COI: Former Pfizer employee, member of the CME/CPD Rome group supported by Serono Symposia International Foundation. Former Pfizer employee, member of the CME/CPD Rome group supported by Serono Symposia International Foundation.
The cooperation between industry and healthcare professionals is important. Many misuses, overuses and underuses of practices have been identified, and all stakeholders have their say in reducing the gaps. Industry collaborates with physicians in many domains: clinical development, epidemiology, and side effects declaration, risk management, etc. There are permanent contacts between the industry and physicians, and the know-how of both parties should be shared.

*Education is one of the areas where industry, speakers and physicians collaborate.*

The attacks on the involvement of industry in CME are common, and European journals publish opinions of non-European experts. Translating the North-American experience to Europe is always difficult. Health care professions are organized differently, and the public sector is stronger in Europe than in North-America. It changes the way people think and view contacts between partners. In Europe, less money is invested in CME than in the United States.

For example, the BMJ published information in the Macy report banning industry support for CME events.2,3

**A FEW WARNINGS SHOULD HAVE BEEN PRESENTED TO THE READERS:**

European and American CME systems are very different; there are less for-profit private medical education and communication companies in Europe than in the United States;

Industry CME investment budgets vary greatly across markets, and European market CME investment is significantly lower than in North America;4 average CME budget is probably between 20 and 50% of mean North American CME investment;

The Macy report was strongly challenged after its publication, as all stakeholders were not on the panel;

Other North American reports with industry representatives on their panels were most balanced, for example the American Association of Medical Colleges.5

**THERE ARE TWO KINDS OF EXTREMISTS IN OUR SOCIAL NETWORK:**

1. The ‘pro-industry’ who are experts desiring money and power; they ask industries to support them in different situations where industry has no say, except paying;
2. The ‘con-industry’ who simply ban contact between the industry and the public health care system; they declare war on the ‘devil-industry’ and promote a witch-hunting policy.

The ‘pro-industry’ have no share of voice to publicly claim their position, as they prefer being anonymous.

The ‘con-industry’ spends time gaining a share of voice and appeal to the public for help.

The partnership of the industry with professionals

In Europe, like in North America, the industry is the major supporter of educational programs, representing on average 50% of the support of CME events in the main countries. With such an investment in CME, the industry shows that it wants to participate in the continuous improvement of health care quality, and facilitates the adoption of innovations in the best interest of the patient.

The industry provides innovative drugs and medical devices to the community. Once approved for the market by national or international agencies, the drugs and medical devices are used by health care professionals to improve the patients’ care. Having developed these products for years, the industry is best placed to participate in their implementation. Education is useful to accelerate the adoption of innovation, and to assure that the adoption will be done according to the recommendations of the market approval.

Educating physicians and other health care professionals is necessary for them to understand and apply the innovation. Information is channelled through the sales reps for promotion, and through accredited programs or accredited providers for education. Business goals are compatible with a better education: all stakeholders win when they promote good practices. Unmet medical educational needs are numerous, and the industry helps in promoting education in many fields. In most European countries, CME programs are accredited and funding by industry is done according to strict codes of practices.

HEALTH CARE PROFESSIONALS AND INDUSTRIES ARE PARTNERS AND MUST COOPERATE AIMSING FOR A WIN-WIN SITUATION:

‘I have an apple and you have an apple. If I give you my apple, and you give
me your apple, we both have one apple. I have an idea and you have
an idea. If I tell you my idea, and you tell me your idea, we both have
two ideas.’

For medical devices education, partnership of the industry is
better accepted

The case of education for medical devices has not been extensively studied
in terms of bias. It differs from the education provided by drug companies. Education in surgery for example needs mentoring, practical and table
courses: the devices and techniques are taught by experts used to specific
devices, and cannot use ‘generic names’ that don’t exist. The company
employees are often better placed than experts to show how a device works.
Education in surgical fields differs from education of ‘medical’ physicians.

For the adoption of medical devices, the need for education is important.
For example, in laparoscopic surgery, there are new trocars, new instru-
m ents developed by industries. Giving these tools to surgeons without
training could lead to accidents. Education is important, and the industry
role is important, as company employees know how to use or implant a
device.

The professionalism and
legitimacy of industry

Industry is always controlled and its professionalism is a guarantor of good
practices. The industry is usually compliant with many regulations, and as
such industry will follow best practices in CME. The industry regularly ap-
praises its staff after regular trainings. All personnel are under scrutiny, and
they have to pass internal and external auditing.

The industry disseminates the critical appraisal of literature, and clinical
epidemiology programs. Professionals should be able to choose to attend or
not attend a program. If they are well trained, they should be able to dif-
ferentiate biased from non-biased educational programs.

The concepts of return on education (ROE) are less employed in Europe
than in North America. Changing practices and behavior of physicians
takes time and effort. The sales representatives obtain short-term results,
but long-term outcomes are obtained by CME. Industry CME leaders observe that single CME programs cannot be expected to significantly advance medical knowledge or rapidly change physician behaviors. The formula for positive CME outcomes involves an integrated mix of audience targeting, program deployment, multiple delivery channels and frequency. The directors of medical education in European industries have difficulty promoting these concepts when they face marketing managers to allocate resources.

Financing and conflicts of interest

A survey was done in 5 countries in 2005 (Italy, Spain, France, Germany, UK) based on questions to key opinion leaders in CME. Based on declaration, it was estimated that 50% of the funding was from the industry, 25% from the employers (hospitals, health services, etc.), 15% from doctors themselves, and 10% from medical societies/medical associations. Large variations were observed between these 5 countries: for example, 75% of the funding of CME comes from employers in the UK, 70% of the funding comes from the industry in France.

There are really few precise data on the funding of CME in Europe. Some national bodies publish few economical data. In Eastern Europe, there are few data on CME funding that mainly originates from the industry.

For example, we conducted a survey in France with 300 hospital doctors, randomly selected to represent all hospital doctors. For live in-class events, nearly 65% of education, travel, and lodging expenses were paid for by the physicians or their hospitals. The pharmaceutical industry covered 25% of these expenses (usually directly supporting expenses). Physicians were asked if there was enough hospital funding to meet their educational needs: 110 physicians (37%) were satisfied, 183 (61%) were not satisfied, and 7 (2%) did not comment.

Financing is sometimes controversial as there are many stockholders in CME: all have their bias, but when they have a public mission, they seem to alleviate their potential conflicts of interest. Industry employees are sometimes lost in wonder when experts request high fees for a conference: full-time salaried clinical faculty at schools should be expected to teach in the CME programs sponsored by their institutions, as part of their jobs.

Cons of industry support have few convincing proposals: physicians and
public institutions should pay for CME, education of small groups when there are thousands of physicians, centralize funds when stakeholders of private companies have no reasons to invest without return on education. Are doctors ready to pay for their own CME?

CME is structured differently in Europe compared to America. For example, the US Pfizer position to cut all funding to third party medical education and communication companies (MECC) cannot be applied in Europe for many reasons: MECCs have a small market share in Europe compared to physicians associations and academic societies. In Europe, schools of medicine and hospitals are rarely important or national players in CME.

The new generation of physicians has a different way to practice. They have learned methods to analyze the literature and critical appraisal is becoming common in Europe.

The new generation is not prepared to accept biased messages from the industry, and they want to understand all actions and side effects of drugs.

Codes of ethics in Europe

Most European countries have codes of conduct for physicians, and these codes usually include some guidance for CME events. These codes contain recommendations for commercial support of CME. The topic is not as high as in North America, probably due to the fact that private medical education companies have a less important role in medical education. But, other biases exist when medical associations are leading the CME marketplace. The EFPIA has a code of practice, but there is not an article dedicated to CME.

On the EFPIA website, there are numerous national codes of practices on the promotion of medicines per country that you get when you type ‘medical education’ in their search engine “http://www.efpia.org/Content/Default.asp?PageID=296”. The industry has not drafted a specific code of practice on the relationship with accredited CME providers/events.

Let’s take the example of France, where a code of practice has been signed between the Minister of health and the president of the drug industry union (medical devices companies were not convened at the table). This code was implemented late 2006, and is based on the French law designing the CME system. When industry supports a CME event, the following criteria must
be met: scientific and andragogic quality of the event (the company cannot influence the content), program must comply with the guidelines and good practices, financing must be transparent and disclosed, no promotion on the event site, usage of generic names during the educational program. It’s also mandatory for a speaker to disclose his conflicts of interest, but it’s rarely done. Declaring conflicts of interest is still awkward for speakers and the audience. It takes time to be fully implemented in a country, as understanding of the concept is poor for most of the participants! There are few data assessing if the code of practice is applied, but there are no complaints. However, it does not mean that biases do not exist there!

Variations of practices in Europe

The majority of companies do not utilize a globally centralized function for CME management. Decentralized structures are more typical, reflecting the local market requirements. On the mid-term, centralized CME structures should prevail as budgets and headcounts will be mutualised at the European level. To produce cost-effective CME, companies know that programs must be developed once and then translated into local languages.

There are differences between European countries that make European codes of conduct difficult to apply. For example, the pharma industry can be a provider in Spain; on the contrary, funding of CME is very low in countries such as the UK.

Distance learning is not developed all over Europe, and funding of programs by the industry is not always permitted. About 10% of CME is done by e-learning in Europe, compared to 20 to 25% in North America. In France, e-learning is not really implemented, and industry cannot assist in the development of these programs. Few countries accept credits for distance learning programs (Spain, UK.); the EACCME started to accredit long-distance learning programs on April 6, 2009. (www.eaccme.eu).

Performance improvement started in the USA in 2004, but is not enforced in most European countries. For example, PI cannot be funded by pharma industries in France (called EPP for évaluation des pratiques professionnelles) when other CME/CPD activities can be funded, according to the local code of practices for education organized by accredited providers.
The show must go on

The endless debate between pros and cons of industry support will continue with no clear solution, as crooks will survive. The assumption that the worst behavior is the average behavior of all physicians insults the profession and its partners.\(^3\)

Europe has often been influenced by US behavior in recent years. That raises the question: Will European Professional Medical Associations (PMAs) be attacked as was seen in a 2009 JAMA article seeking a total ban of relationship between PMAs and industry?\(^4\) The recommendation was to totally remove industry support of PMAs and hold officers of the PMAs accountable for avoiding any industry support. Many PMAs officers were offended. The American College of Cardiology president took a strong position for a system that works: “The proper relationship should allow us to work with industry and allow our professional societies to receive undesignated funds from industry to foster better patient care…… We do not need a world of total disengagement; we need a world where responsibility and professionalism set the standards of relationship with industry, and the rules that we create to support this behavior are based on the best interest of our patients.”\(^1\) To define the physicians’ relationships, the term ‘multiplicity of interest’ has been proposed by the American Association of Clinical Endocrinologists, and the American College of Endocrinology.\(^5\) The relationship between physicians and third parties, including pharmaceutical and biotechnology companies, is moral, ethical and legal.\(^5\) Medical education is an important part of this relationship.

I spent half of my professional career in the public sector and half in pharmaceutical industries: I observed fair people and crooks in both sectors. I cannot confirm that people are good in the public sector and bad in the private sector, but this idea is spread by extremists. We will always have to deal with crooks in both sectors, even if the systems try to put them aside.

I was always surprised by the behavior of people who avoid speaking to people from the ‘other side’. They are back in the dark period of McCarthyism, and promote the witch-hunting that leads to nothing.

Instead of opposing industries and health care professionals, we should consider wisdom and transparency, finding the best ways to cooperate.
References


http://www.josiahmacyfoundation.org/documents/pub_ContEd_inHealthProf.pdf


7. Green JS, de Boer PG. AO principles of teaching and learning. AO publishing, Duvois & Thieme, New York 2005


11. European Federation of Pharmaceutical Industries and Associations (EFPIA) code of practices on the promotion of prescription-only medicines to, and interactions with, healthcare professionals. October 2007, 24 pages.

http://www.efpia.eu/content/default.asp?PageID=559&DocID=3483


CLOSING STATEMENT:
10 STEPS TO EVOLVE CME IN EUROPE

THOMAS KELLNER*
What can we learn from today’s Europe? There is power in respecting diversity and focusing on common needs and interests. There is empowerment of opportunities due to a culture valuing collaboration. Where is the common ground within CME? How can European CME evolve from its current state? Assumptions need to be validated related to their reliability or sustainability, barriers need to be identified and reduced, and opportunities need to be realized, systematically evolved and sustained. Changes need to be pragmatic and contribute to better outcomes. The appropriate processes and standards must be introduced to assure efficient and effective delivery and execution of future education.

*COI: Thomas Kellner – Full time employee of MSD (Pharmaceutical Industry)
10 Steps to Evolve CME in Europe

INVOLVE
Collaborate with all relevant stakeholders in the healthcare system to contribute to designing future standards for healthcare education.

PRIORITIZE
Empower best practice related to achieved patient outcomes. Prioritize changes having the most impact on maximizing educational and patient outcomes.

ASSESS
Define a system built on gap assessment around the core competencies of healthcare professionals. Make the educational needs assessment the cornerstone of program planning.

ELIMINATE
Identify critical barriers for change and eliminate ineffective or inefficient processes, procedures or definitions related to CME standards or, more in general, the planning and execution of health-related education.

DESIGN
Apply a planning and execution process built on instructional design. Use those formats for execution that serve the needs of the audience related to their learning style (adult learning principles) and those being the most appropriate to eliminate identified gaps.

FUNDING
Make the funding model a fundamental question that requires to be answered before introducing restrictions and limitations. Critically assess potential restrictions and their impact under a 360° perspective. Investigate means and triggers to attract sponsors. Recognize the dimensions of funding: medical education is part of the overall healthcare system; outcomes need to be maintained with existing healthcare budgets, but also require meeting the needs of patients. There should be a rational applied to funding of education and funding of the overall healthcare system.

EVIDENCE
Define criteria to identify and reduce inappropriate influence/bias. Be well-aware that a component of bias is related to the human being and dynamics
in the social environment. Bias is not automatically associated with commercial organizations contributing to the healthcare system. Apply the principle of scientific evidence, introduce peer reviews and spontaneous audits of qualified auditors to assure quality and fair balance.

**MEASURE**

This includes recognition of CME/CPD credits beyond geographic borders. Introduce measures related to improved performance instead of learning hours or incentivizing or penalizing educational programmes due to the origination of learning content. Make evaluations of achieved outcomes (in perspective to identified gaps) mandatory and the basis for learning recognition. A rapid evolution of programs into maximizing quality will be the consequence.

**IMPLEMENT**

Realize progress pragmatically and step by step. Apply principles of change management to make changes happen. Train stakeholders or personnel in educational functions or roles to apply appropriate standards.

**SUSTAIN**

Continuously monitor performance and improve. This includes actions to be initiated and executed for violating standards.

A critical factor for the success and the evolution of healthcare related education is its recognition in public and the professional community. Without a doubt, CME/CPD as it is today has already proved to be a substantial contribution to improving healthcare management. In the evolution of guiding principles, standards and operations related to education is important to keep the focus on the “e” – whereas this letter stands for “e”ducation.

By focusing on education and achievable outcomes, the scope of what is being addressed and covered by health education may become bigger and involve more stakeholders than today. This will also imply that the classic terms and definitions of CME/CPD might evolve into something far broader. Beyond all the complexity and factors to be considered, we may constantly remind ourselves: The purpose of health education is improving patients’ health with the most efficient and effective means under the given circumstances and opportunities. This is no revolution, but an evolution from where we stand today.
**ABOUT THE AUTHORS**

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Eric-Jean is Chief Executive Officer and co-founder of MedEd Global Solutions, a medical education agency created in 1998, the first company in Europe to deliver accredited e-CME programs since 2009.

He has a broad background in the healthcare industry as well as extensive experience in a number of fields, including hematology, anesthesiology, intensive care medicine, rheumatology, pediatrics, CNS and cardiology. Eric-Jean holds an MSc in Biology from the University of Paris VI, France. He has wide experience in medical education, including strategy development, publications planning, development of sales force/medical liaison and speaker educational programmes, development of educational videos/interactive games, and implementation of materials including primary publications, review manuscripts, abstracts, posters and slide presentations.

Before founding MedEd Global Solutions, Eric-Jean was Director of the International Business Division at Gensia Pharmaceuticals. Prior to Gensia, Eric-Jean served in a variety of executive capacities at Pharmacia & Upjohn.

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Bernard Maillet was schooled at Antwerp University as an MD and received his postgraduate training in Surgical Pathology at the Academic Hospital of the Free University of Brussels (VUB). During his training, his research topic was the pathology of the gastro-enterologic tract and more precisely the pancreas. This resulted in many publications as co-author and communications with his mentor, Prof. Dr. Günter Klöppel in pancreas carcinoma and chronic pancreatitis.

Soon he was involved in the Professional Organization of Pathology in Belgium, first as a member of the Board and then as one of the Secretaries. This lead to his involvement in the Belgian Medical Specialist Organization GBS-VBS, first as a delegate for the Pathologists in the General Assembly, then as a Deputy Secretary-General, and now he is the Treasurer of the VBSGBS.

In 2002, the VBS-GBS proposed Dr. Bernard Maillet as candidate Secretary-General for the UEMS.

Conflicts of interest: None to declare.

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He is medically qualified from the University of Lyons (1979) with business administration qualifications (Certificat de Perfectionnement aux Affaires, Paris, 1994). He practiced clinical medicine for ten years in the Lyons hospitals. He spent 10 years in clinical development in the pharmaceutical industry. In 1994 he joined the Agence Nationale d'Accréditation et d'Évaluation en Santé (ANAES), Paris, initially as Clinical Guidelines Director, then as Evaluation Director. He was responsible for the development and implementation of clinical guidelines, consensus conferences and the evaluation of health care professional practices throughout France. He was the editor of www.websurg.com in Strasbourg (2000-2004), an accredited elearning activity. He was director of Continuing Medical Education at Pfizer France (2005-2009).

He has had close involvement with leading international journals through his role as a president (1994-1997) of the European Association for Science Editors (www.ease.org.uk), and chiefeditor of European Science Editing (2000-2006). He has published books on medical writing in French (La Rédaction Médicale, 5th edition 2010, Le Guide du Thésard, 6th edition 2010). He publishes editing news on www.h2mw.eu

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Thomas Kellner, Leader Global Medical Education at MSD holds a medical degree from the University of Munich. After his internship he began working as an e-strategy consultant in a new media company, quickly rising to leader of the healthcare division. He joined MSD Germany for managing the launch of a portal for healthcare professionals, today known as Univadis®. He has held various national and regional positions over the 9 years he has been with MSD. He is currently leading the global medical education strategy and grant management process at MSD.

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Dr. Peter Posel, MD, is currently the CEO of QUAIME AG, Switzerland. He has developed successful projects on user adapted e-learning programmes and interdisciplinary collaboration projects in blended learning settings. He received an academic background in basic medical sciences from the universities of Regensburg and Munich (PhD in medicine 1981, GP license 1985). He then taught clinical anatomy and was responsible for “new media in education” at the Anatomical Institute of the University of Munich between 1979 and 1992. From 1992 to 2005 he held different leading positions in the pharmaceutical industry (Lederle, Wyeth, Biogen, national/international). Starting from 2005 Dr. Peter Posel worked as a consultant in e-learning and media for companies, associations and institutions.

He performs active membership in different medical societies, such as World Forum CPD in medicine, GAME, German Anatomical Society. His interests are outlined in numerous publications and presentations on clinical anatomy, neurophysiology, Family Medicine, and social politics as well integrated health care.

Conflicts of interest: Received educational grants from MSD, Essex Pharma.

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Alfonso Negri, MD

Dr. Negri has been involved in the complex evolution of CME in both the E.U and the U.S. since 1999, and not only founded the system in Italy, but has closely watched the development follow European paths. Dr. Negri is a Medical Foreign Committee Member of Italian Federation of Medical Societies and a founder of the first accredited event in Italy, the National Pneumology Congress, a landmark in CME history.

Because Dr. Negri was a member of various commissions of the Italian Federation of Medical Societies, he began helping others follow a European CME path. His work developed as the rest of Europe started opening up to CME, and Dr. Negri is now a board member of the Global Alliance for Medical Education and various accreditation committees of international medical societies.

Dr. Negri is founder of the Rome Group, an international group of experts from North America and Europe in Continuing Medical. Dr. Negri will work closely with Veglia and the ABTS team in Rome and Miami to provide support services for all Association clients through alliances with (UEMS) and European Accreditation Council for Continuing Medical Education.


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Continuing Medical Education in Europe: OR EVOLUTION?