CONFERENCE REPORT

State of Play of CME in Europe in 2013: Proceedings from the Sixth Annual Meeting of the European CME Forum

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Abstract

European CME Forum is a not-for-profit organisation that is dedicated to bringing together all stakeholder groups with an interest in European Continuing Medical Education (CME) in order to promote multi-channel discussion in an independent and neutral environment. This report summarises the presentations and discussions that took place at the Sixth Annual Meeting of the European CME Forum, held in London on the 14th and 15th November 2013, which was preceded by a series of ‘Day 0’ meetings as pre-meeting sessions for delegates from specific interest groups. The predominant target audience comprised people with an interest in European CME including the accreditation bodies, scientific societies, education providers, industry and European medical communications agencies. The year prior to the meeting saw the introduction of new accreditation standards from UEMS-EACCME, with other accreditors examining how they should be evolving their own; the introduction of the US Physicians’ Payment Sunshine Act and its rather unexpected ramifications in Europe; pharmaceutical companies also starting to employ the grant process for funding CME, and their own increasing insistence on being hands-off from CME programmes. This in turn has led to education providers needing to be more knowledgeable and accountable and looking for their own guidance to help them navigate these evermore complicated waters. Against this back-drop, session themes for the sixth annual meeting were focused on sharing best practices and identifying what constitutes good CME in practice, discussing the role of industry in CME, summarising the latest trends relating to accreditation in Europe, discussing the current legal and regulatory frameworks impacting on CME, and communicating new innovative CME ideas (e.g. relating to e-learning).

Keywords: CME, accreditation, Europe, providers, best practice, regulation

Introduction

Eugene Pozniak (Programme Director, European CME Forum, UK) opened the meeting by providing an overview of the significant milestones that have occurred within European CME over the previous 12 months. Firstly, participants were reminded that the Journal of European CME (JECME) is now launched and were told that it has a new publisher – Co-Action Publishing – that is dedicated to open-access publishing. An update was also provided on the Good CME Practice Group (gCMEp; http://www.gCMEp.eu/), which now comprises 16 European Providers. Most significantly, the gCMEp Group is currently in the process of developing a comprehensive CME Toolkit to help guide providers when securing
funding for and implementing CME-accredited educational programmes. Other key milestones that have occurred in the CME field over the 12 months prior to the meeting are summarised in Table 1.

In order to inform the content of the Sixth Annual Meeting of the European CME Forum, a survey was conducted to gauge the views of the broad CME community. Overall, 91 people completed the survey between June and November 2013. The survey completers were mostly from Europe, with around a third from North America. The completers were from a wide variety of roles, including CME accreditors and healthcare professionals (HCP) (learners) (16% of completers), providers (57%) and industry (16%). The five most important topics that arose from the survey were 1) related to measuring outcomes of CME programmes, 2) looking at how CME can have an impact on clinical practice, 3) examining how to guarantee the quality of CME programmes, 4) looking at the transparency of relationships between industry and CME, and 5) examining how to carry out a good needs assessment. Additionally, participants in the survey were asked which scenarios cause them most concern. The findings are summarised in Figure 1. Overall, the quality of CME programmes was the issue that causes most concern, followed by how CME will be funded if industry is excluded.

A key objective in developing the agenda for the sixth annual meeting was to ensure that the issues raised in the survey were discussed. In this regard, the first session of the forum was centred on improving good CME in practice.

**Session 1: Good CME in practice**

As the next step following the publication last year of its ‘core principles’ in the manuscript ‘Setting CME standards in Europe: guiding principles for medical education’, the Good CME Practice Group is developing a ‘CME Toolkit’ to help guide providers through the plethora of rules and expectations associated with developing and presenting CME-accredited activities. This toolkit will provide direct advice on how to address all the points the CME accreditation bodies require through to navigating copyright fees for CME programmes. By way of a workshop format, this session of the meeting covered many aspects of the toolkit, including investigating the challenges that European providers face not just for CME compliance, but also from the regulatory and legal perspectives of the other parties involved.

The workshop started by asking the audience what they believed to be the good, bad and ugly sides to CME in Europe at the current time. The feedback given is summarised in Table 2.

The audience was then engaged in a workshop that considered best practices relating to needs assessments, disclosures, and evaluations. The findings of this workshop are summarised below.

**Needs assessments**

Regarding needs assessments, it was agreed that CME providers should ensure that educational activities have clear learning objectives that are derived from a coherent and objective process that has identified performance gaps and unmet educational needs. The education must be designed to positively to reinforce existing good practice and effect a sustained change in daily clinical practice as appropriate. In order to conduct an effective needs assessment, multiple tools should be used. Examples include: 1) literature review (randomised controlled-trials, guidelines and reports), 2) past activities (feedback and experience), 3) expertise of faculty, 4) survey of target audience (paper, online, etc.), 5) focus groups (patients, expert and learners), and 6) benchmark of existing activities. The learning objectives identified through this process should be realistic, specific and measurable in the evaluation process.

**Disclosures**

The aim of disclosure is ultimately to ensure that medical education is free from bias. Disclosures should be collected at initialisation of the education programme to enable any conflicts of interest to be identified early. Disclosures should include anything that could be perceived

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### Table 1. Milestones in the 12 months prior to the Sixth European CME Forum.

| Time period | Milestones |
|-------------|------------|
| Q1-Q2 2013: January-May | - January: European Union of Medical Specialists (UEMS) new standards for accreditation of live events launched |
| | - March: 2nd Essential Guide to CME (London, UK) |
| | - April: Dissolution of the UK’s Ethical Standards in Health & Life Sciences Group |
| | - May: gCMEp Spring Meeting (London, UK) |
| | - May: Inaugural meeting of International Academy for CPD Accreditation |
| | - June: Global Alliance for Medical Education (GAME) meeting (Barcelona, Spain) |
| | - June: European Board for Accreditation in Cardiology (EBAC) Provider meeting (Frankfurt, Germany) |
| | - June: British Medical Journal (BMJ) and Association of the British Pharmaceutical Industry (ABPI) joint meeting on CPD in the UK (London, UK) |
| | - August: UEMS reduced the time for review for accreditation of live events to 12 weeks |
| | - August: Association for Medical Education in Europe conference (AMEE) – Essential Course in CME (led by University of Toronto), also session by GAME raising the profile of CME |
| | - August: US Physician Payment Sunshine Act implemented |
| Q3 2013 | - September: European Federation of Pharmaceutical Industries and Associations (EFPIA) new statement on responsible transparency |
| | - September: 2nd Cologne Consensus Conference (Cologne, Germany) |
| | - November: Taking place on ‘Day 0’: First live meeting of the International Academy for CPD Accreditation, Autumn meeting of the Good CME Practice Group, meeting of the Scientific Societies, International Pharmaceutical Alliance for Continuing Medical Education (iPACME) |
| Q4 2013 | - November: Taking place on ‘Day 0’: First live meeting of the International Academy for CPD Accreditation, Autumn meeting of the Good CME Practice Group, meeting of the Scientific Societies, International Pharmaceutical Alliance for Continuing Medical Education (iPACME) |
to be relevant to the activity or presentation (financial and non-financial). The programme director and/or an independent expert should review all disclosures, ideally. If necessary, additional information regarding potential conflicts of interest should be requested if anything is ambiguous. Once obtained and reviewed, disclosures should be communicated in multiple places in order to aid transparency to the learners. This may be done on a slide at the start of a presentation, in a programme book and on a website if it relates to an e-learning activity.

Evaluation

The final aspect of good CME practice that was discussed in this session was evaluation. At the current time, providers are not good at measuring the outcomes of events. Although evaluation forms are almost always in place, the intention is often not well considered. We should not just be thinking about the learners’ satisfaction with the meeting. We need to try to understand how the meeting will change practice. In order to achieve this, the following topics should be considered on all evaluation forms: 1) overall meeting evaluation, 2) teaching effectiveness, 3) learning objectives, 4) comments about the content presented, 5) measurable change, 6) bias during the programme, 7) accreditation and certificate purpose, and 8) comments. In addition, when developing an evaluation form, providers should consider who needs the evaluation form (what is its purpose?) and who should receive the results?

### Table 2. Summary of the good, bad and ugly sides to CME in Europe at the current time.

| Good | Bad | Ugly |
|------|-----|------|
| • Gaining impact/importance of CME | • Lack of uniform quality standards | • CME does not fit in with how doctors learn |
| • A lot of interest – including in emerging markets | • Accreditation only quality standard we have – but is not a good standard | • Doctors are not the best educators |
| • Increases professionalism | • Need better vision of how quality should be measured | • Still a lot of industry involvement/bias – decreasing in N America/Europe – but increasing in emerging markets |
| • Keeps doctors up-to-date | • Disjointed: different countries have their own rules, and different therapy areas have their own rules – making it difficult to run programmes at a regional/international level | • Lack of consensus – most likely due to differences in healthcare systems |
| • Feel good factor of regulated CME | • Lack of clarity as to where European CME is headed | • Blanket CME at congresses – even if clinicians do not attend sessions they will still gain CME accreditation |
| • Doctors like being educated | • Lack of ability to measure efficiency | |
| • More and more physicians are aware of CME | • Reluctance of doctors to keep up-to-date | |
| • More information available about what constitutes quality – and finding its way into programmes | • Increasing complexity | |
| • High-quality education activities are available | • Misconceptions about rules | |
| | • Lack of consensus/understanding from doctors about what CME means | |
The standards laid out in this session, which will ultimately be detailed in the ‘CME toolkit’, are imperative to helping to raise standards in CME within Europe.

**Session 2: Providing for the profession**

European specialist societies are the main providers of CME for hospital doctors in Europe. This session provided an opportunity for experts from several key societies to discuss how the provision of CME is changing and evolving in Europe.

**CME in pulmonology**

Martin Balzan (European Board for Accreditation in Pneumology, Malta) gave an overview of the complex situation governing CME in Europe, with a specific focus on the accreditation of educational activities in respiratory medicine.

He pointed out that the responsibility for the regulation of CME in Europe is not with the European Commission. Instead the responsibility for the regulation lies with national bodies – and in some cases this is done on a voluntary basis, while elsewhere it is mandatory – depending on the country. To further complicate this picture, CME can be managed by either professional self-regulation or government regulation – again depending on the particular country.

At a country-specific level, it is possible to gain accreditation of activities through either national medical associations (for example in the UK, where membership can be voluntary) or national medical chambers (for example in Germany, where membership is compulsory). Pan-European accreditation of internationally relevant activities can be gained through the European Union of Medical Specialists (UEMS) and its European Accreditation Council for CME (EACCME). European-wide accreditation through this route is associated with several benefits – including political leverage and freedom of movement of CME points across borders. EACCME accreditation can also be obtained via European Specialty Accreditation Boards (ESABs). At the current time, European specialist societies are the major providers of CME and this route of accreditation is associated with three main advantages: financial and organisational capacity, technical know-how for each speciality and support at the grass roots level.

Until recently, UEMS and European specialist societies were disparate groups in terms of CME provision. However, there is room for partnership. A good example of what might be possible is the current relationship between the European Board for Accreditation of Pneumology (EBAP), the UEMS and the European Respiratory Society (ERS). The EBAP board includes members from UEMS and ERS – which is helping with broader collaboration. The main role of the ERS is as a CME provider (of congresses, written journals and e-learning materials) and it has supported the formation of the HERMES project to prepare curricula in both adult and paediatric pneumology.

An agreement has been signed by the ERS with the UEMS section where co-operation is defined, in particular with respect to the development and updating of curricula, and the recognition of the HERMES curriculum and examination by the UEMS Pneumology Section and the UEMS Executive. This agreement has been in place for 1 year so far and appears to be working well with mutual benefits to both the ERS and UEMS.

**From training to CME quality circle**

Wolfgang Grisold (World Federation of Neurology, Austria) provided a detailed insight into the development of examinations for the European Board of Neurology (EBN). This examination is necessary for doctors in certain countries to become recognised as a neurologist. A core curriculum has been established which includes essential topics such as skills, knowledge, competence and attitude. This was achieved through consultation with scientific committees from European neurologic societies and other specialist societies who helped develop a catalogue of topics and examination questions.

The written examination consists of 120 multiple-choice questions (MCQ) and a series of extended matching questions (EMQ). The MCQs were designed to test factual knowledge, comprehension, application of knowledge and problem solving, and clinical reasoning abilities to a lesser extent. In contrast, EMQs are designed to test problem solving or clinical reasoning abilities to a much greater extent than MCQs. They consist of clinical scenarios combined with possible options relating to the scenario. Each clinical scenario must be matched with one of the options from the list. An example of an EMQ is given in Figure 2. In addition to the written examination, candidates have to complete a 5-minute case presentation, which is rated on the detail given of the patient's medical background, discussion of the case and clinical reasoning, logical presentation of the content, communication skills and competence of knowledge. In 2013, 30 candidates were accepted to take the examination with 25 achieving a pass.

These examinations are important for assessing the expertise of individual doctors. However, to improve patient care, it is also imperative to assess the neurology centres where the individual doctors work. In this regard, department visits are also considered important in terms of assessing provision of training in neurology within Europe, and the UEMS provides a structured protocol for such visits. Interviews are conducted on various aspects of training with residents, faculty members, teachers and hospital management in addition to an assessment of the clinical departments. An evaluation report is then provided to the department with suggestions and recommendations.

In summary, the quality circle advocated by the UEMS and EBN encompasses training, visitation and examination. Further information on this can be found in a recent publication by Struhal et al.\(^2\)
Providing education for the profession: the role of the medical society

According to Susanna Price (European Society of Cardiology [ESC], UK), there is a clear need for high-quality CME and continuing professional development (CPD) – and education is fundamental to good medical practice. Continual advances in medical science mean that clinical practice changes rapidly and CME/CPD ensures that cardiologists keep their standards, skills and knowledge up-to-date, thereby resulting in improved patient care.

In some countries, such as the UK, CPD forms part of the mandatory process of revalidation that doctors have to undergo on a regular basis in order to confirm their continued fitness to practise. A survey of consultants commissioned by the General Medical Council in the UK looked at many different aspects of CPD. Reassuringly, most (87%) consultants stated that their motivation for undertaking CPD activities was due to interest in learning. The vast majority (91–97%) thought it was a necessary and natural part of professional life. Most of the survey respondents also thought that college and faculties should continue to be responsible for the quality (88%) and curriculum content (83%) of CPD. In this respect, specialist societies play a large role in providing accessible and relevant CME/CPD. One example of this is the ESC’s online educational website (http://www.escardio.org/EDUCATION/Pages/welcome.aspx), which offers a core curriculum, access to an e-learning platform, registration for live events, and links to practice guidelines. Currently, it is aimed at trainees and aims to harmonise training across Europe. Changes due to be introduced next year will address those already qualified and will facilitate tracking of CME/CPD.

A key challenge that cardiologists face is the need to stay current in what is an increasingly multidisciplinary and fast-moving discipline, while trying to identify relevant educational materials. Finding the time to do this while maintaining a busy full-time job is difficult. As a consequence, there is scepticism among some individuals as to whether CME makes any difference. An additional challenge is ensuring that any relevant activities are free from commercial bias, and in this regard the ESC has recently published a white paper in relation to conflicts of interest. However, despite these challenges and complexities, the overriding conclusion is that provision of high-quality CME/CPD should remain an absolute requirement for cardiologists.

Session 3: eCME: a SWOT analysis

A variety of eCME tools and approaches were discussed in this session, ranging from online courses through to game-based simulations.

eCME: a SWOT analysis

As well as providing a brief update on eCancer – a not-for-profit organisation offering a variety of educational and
Eugene Pozniak et al.

In the future, MOOCs will become much more widespread and popular. It is likely that medical education is developing, the fact that the pharmaceutical industry is under siege (with potential impacts on funding), the communication overload online (who to trust?) and that specialists increasingly have less budget/time for conferences. For established eCME portals such as eCancer, the biggest potential threat comes from the development of Massive Open Online Courses (MOOCs). The benefits associated with MOOCs include availability in multiple languages, flexible access, short timeframes for production and delivery of courses and facilitation of multidisciplinary learning. Medical MOOCs are currently US-focused (e.g. through Coursera, see https://www.coursera.org/), but European organisations are also rapidly becoming involved. MOOCs may be considered as a competitor to eCME tools such as eCancer due to their ability to attract large numbers of candidates. It is likely that medical MOOCs will become much more widespread and popular in the future.

In contrast, a steady rise has been seen in the uptake of live CME courses over the past 10 years. There may be many reasons behind this, including that eCME has traditionally not offered opportunities for practical experiences, social interaction, and discussion. It is becoming increasingly apparent that e-learning needs to be used in conjunction with other CME activities to achieve the best results for surgeons.

A number of approaches have been used by the PBGS to address the shortcomings of traditional eCME. Firstly, the PBGS have found that the concept of blended learning, which is the combination of e-learning and onsite training, seems to give the best of both worlds. Theoretical knowledge can be delivered in advance of attending a hands-on workshop through eCME, and this enables time to be used much more effectively during the onsite sessions. Secondly, PBGS has introduced mobile learning, where all website content is available as smartphone or tablet ‘apps’, thereby providing rapid learning at the point of interest. Thirdly, a PBGS collaborative learning social network has been introduced that offers learners the opportunity to engage with peers through professional social networking, expert chat forums and special interest groups. The final approach from the PBGS has been to introduce mind/motor training (mental training) online, which encompasses the provision of highly effective cognitive simulation tools that allow surgeons to prepare and practise a technique before trying it out on a patient.

In conclusion, a combination of approaches is likely to give the best and most efficient results for achieving successful CME.

eCME highlights: best practice from technology-enhanced learning in medical education

Peter Henning (Karlsruhe University of Applied Sciences, Germany) stated that eCME is now part of mainstream teaching. However, major advances to technology-enhanced learning are emerging. In this regard, Dr Henning focused on examples of best practice in e-learning, and in particular activities that have been nominated for awards, such as the European Award for Technology Supported Learning (eureleA).

The development of online game-based learning is considered as one of the most important innovations in teaching. In this regard, ‘playing’ is one of the oldest evolutionary strategies for the learning of complex patterns, structures and processes. From a medical perspective, game-based learning can facilitate hand–eye coordination, decision-making and development of leadership skills. This concept was used in the development of the INMEDEA simulator (www.inmedea-simulator.net), which is based around a virtual clinic and trains the user in diagnosis and therapy processes. Another game-based tool is available from LINE (www.line.co.uk) in which users interact with a virtual skeleton to facilitate bone fracture classification.

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Jörg Ansorg (Professional Board of German Surgeons [PBGS], Germany) gave an overview of the PBGS Academy, which runs more than 100 CME courses a year. Since 2002, the Academy has also hosted an e-learning website (www.ecme-center.org) which offers more than 900 online courses. Uptake of these eCME courses increased dramatically until 2009, but has declined fairly rapidly since then.

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Another advance in e-learning comes from the development of new learning machines. For example, the Intelligent Tutoring Interface for TEL (INTUITEL, www.intuitel.de) is an e-learning system that encompasses information about a learner in a pedagogical model. This enables the interface to act like a skilled teacher that provides guidance to the learner and directs the user through an optimal learning pathway.

Other innovations in e-learning include new interfaces – such as non-touch interfaces and large interactive touch screens. Non-touch interfaces (similar to the Nintendo Wii and Microsoft Kinect) can dramatically improve learner interaction with computer-based systems, for example through the touch-free control of images in operating theatres. Large touch screens have been developed that enable an entire team to interact with and treat a virtual patient using a variety of tools and procedures (e.g. http://elearning.charite.de/services/projekte/simmed/).

The final advancement in e-learning will come from new learning paradigms – and in particular MOOCs – and from the involvement of open educational resources (such as YouTube) in the provision of medical training.

Finding a balance between excellence and feasibility in e-learning
Elgin Lichtenauer-Kaligis (European Association of Urology [EAU], the Netherlands) described how the EAU is actively developing an online platform to facilitate access to e-learning courses. Results from a survey of 360 final year urology residents were used to determine which urology topics to include in the courses, the type of device that these should be accessible from, and whether lecture style or active style e-learning was preferred. The urology residents confirmed that they would like e-learning to be provided in an active learning format that is suitable for desktop, laptop and tablet computers.

An example of how lecture style e-learning can be transformed into a much more engaging active e-learning format is shown in Fig. 3. In the active e-learning format, the participant has to drag and drop various options into the correct scenarios requiring considerable thought. Specific feedback can then be provided on each combination and additional information is available for further learning. However, in working up examples such as this, it soon became clear that it takes a significant amount of work to transform lecture style e-learning into an active e-learning exercise, which prohibits timely delivery of learning content in this educational format.

Given that resources are limited within the EAU (similar to any medical society), a pilot project was first initiated that investigated the influence of presentation format on learner satisfaction. An e-learning module (without active learning exercises) was developed in two parts. The first part presented the learning content in a low-cost, traditional online textbook style, with some educational videos inserted and a menu that allowed navigation to topics of interest. The second part was a modern multimedia presentation with limited navigation function-

ality, where the learning content was embedded in an audio-slide show enhanced by video or animations. Somewhat surprisingly, feedback suggested that the traditional textbook style was rated more highly by the users of this pilot than the enhanced slide show. Apparently, the learners valued having more control over accessing the learning content.

What this pilot shows is that when resources are limited, efforts should be put into developing clear, easy to navigate e-learning courses – and that high-quality content always should take the highest priority. Simple measures such as navigation functionality can make a big difference and provide the individual with control over their learning.

Session 4: Industry, clinicians and CME: how well do transparency rules demystify the relationships?
This panel-led session reviewed the new transparency code from the European Federation of Pharmaceutical Industries and Associations (EFPIA), including potential future implications on medical education, and debated the role of industry in the provision of medical education. The panel was led by Eva Thalmann (Janssen-Cilag, Austria) and included Edwin Borman (UEMS-EACCME, UK), Anne Erwin (EFPIA, Belgium), Carin Smend (European Haematology Association [EHA], The Netherlands), Veronica Moy (Merck Serono, Germany) and Jean-Jacques Murama (Eli Lilly, Switzerland).

Recent revisions of the EFPIA Code of practice
There is increasing external scrutiny of interactions between pharmaceutical companies and HCPs in various countries in Europe. This has led to legal provisions (in Denmark, France, Portugal and Slovakia) and self-regulatory provisions (in the Netherlands and UK) for disclosure of data relating to the interactions. This is running in parallel with disclosure activities outside of Europe, and particularly in Japan and the US. Consequently, different approaches are in place at national levels regarding the communication of data disclosure to public authorities and/or publication on publicly accessible websites.

Anne Erwin introduced the new EFPIA HCP/Healthcare Organisation (HCO) Disclosure Code (http://transparency.efpia.eu/the-efpia-code-2). Following the EU Commission initiative on Ethics and Transparency – in the pharmaceutical sector – EFPIA has adopted a ‘List of Guiding Principles Promoting Good Governance in the Pharmaceutical Sector’ (http://ec.europa.eu/enterprise/sectors/healthcare/files/docs/outcomes_et_en.pdf). In line with these new Guiding Principles, this new Disclosure Code responds to society's heightened expectations that interactions between HCPs/HCOs meet the high standards of integrity expected and are also transparent. The Disclosure Code is designed to help encourage a consistent approach to data disclosure in Europe and help guide further action at the national levels.
The new Disclosure Code details how each pharmaceutical member company will need to document any transfers of value it makes directly or indirectly to HCPs and HCOs. Each Member Association (for example the UK Association of British Pharmaceutical Industry [ABPI]) will need to transpose the EFPIA Disclosure Code into its own national code by 31st December 2013. The first reporting period will be the calendar year 2015 with disclosure required in 2016. This time span gives National Member Associations time to determine how the Disclosure Code will be implemented in their own country, ensuring that the minimum standards required are not in conflict with national laws or regulations. In particular, privacy laws will need to be considered.

In general, disclosure will fall into different categories: aggregate, individual HCO and individual HCP. For all
types of disclosure, associations and companies must ensure compliance with national laws and regulations. Research and Development activities including all clinical, non-clinical trials and non-interventional studies, will be fall into disclosure at an aggregate level. Disclosure at the HCO level will be required for donations, grants, travel and accommodation and fees for services or consultancy. At the individual HCP level, disclosure will be required for costs associated with attendance at events or fees for services and consultancy.

Particular attention needs to be paid to hospitality and gifts. Provision of gifts of any kind is now prohibited. The amended EFPIA HCP Code states ‘no gift or pecuniary advantage (in cash or benefit in kind) may be supplied, offered or promised to a healthcare professional’. However, provision of informational or educational materials, or items of medical utility will be permitted, providing certain criteria are met and that such items are ‘inexpensive’. There will also need to be a threshold for hospitality set in each national code. EFPIA will set the thresholds if this has not been done by the Member Associations by 31st December 2013.

The audience and panellists debated the implications and consequences of this new Disclosure Code. The overriding message was that it is about taking responsibility for self-regulation and buying into the spirit of what the Disclosure Code is trying to achieve, which is greater transparency. Working together collectively will make this a success. The alternative is that regulators will become involved and rather than these codes being a self-regulating concept, it could be enforced through legislation.

Concern was expressed about whether the public would be ready for such levels of disclosure and that the media might misconstrue published information. It is likely that the public and the media are unaware of the importance of CME to doctors and ultimately patient care. Consequently, to avoid misinterpretation, there is a greater need for a clear and consistent explanation as to why industry-sponsored education is needed.

An audience poll showed that 86% thought that the new Disclosure Code would change the interactions between clinicians, medical societies and industry. The panel agreed and noted that a fundamental shift in approach will be required by everyone involved, with individuals and organisations working together collaboratively in a trustworthy and honest environment.

Consideration of the role of industry in education
Jean-Jacques Murama described how the International Pharmaceutical Alliance for Continuing Medical Education (iPACME) is a collaboration of medical education experts from the world’s leading pharmaceutical, biotech and medical device companies. iPACME was started 5 years ago as a platform for medical education professionals to share best practice and meets regularly to discuss challenges and issues including a meeting during the previous day’s ‘Day 0’ activities. The aims of iPACME are to help improve the quality of medical education internationally and define the value of industry involvement.

Industry is currently very active within medical education internationally, providing grants and sponsorships, in addition to working in partnership with medical societies, providers and academia to offer the full educational spectrum from assessment of needs to deployment.

Clearly, industry has an obligation to ensure that its products are used safely and effectively but does it follow that industry is responsible for educating HCPs in these areas? An audience poll showed 62% thought that industry and other organisations should be jointly responsible for this. The panel agreed, noting that in order to achieve the best possible education, it is necessary for pharmaceutical companies to work together with medical societies. The question was then asked as to whether the role of industry should be limited to financial contributions or could this be extended into collaborative engagements and partnerships. The audience responses were split with some agreeing that industry should only provide financial support, while others thought there was room for collaboration or full partnership, or that it should be evaluated on a case-by-case basis. The panel concurred that in general, there was room for broader collaboration in some circumstances. However, at the current time, the UEMS’s position is that industry should not be directly involved in accredited educational events. This could potentially change in the future following implementation of the EFPIA Code – and if greater transparency and trust can be proven.

Another question to the audience was whether educational needs can be addressed through CME without any support from industry. The majority of the audience felt that industry backing was required to some degree. The panel commented that a lot of good work comes out of industry supporting professional bodies in the provision of education, and that all organisations need to work together to improve patient care. Additionally, one panelist commented that if industry does not support medical education, it is likely that the financial burden would fall to an even greater extent on governments, who would fund it by increasing the cost of public healthcare services. However, in spite of these benefits, there remains a common public misconception that involvement by industry in physician education leads to bias and is to be avoided. Overall, it is clear that the role of industry in the provision of medical education is a hot topic and will continue to be debated for some time to come.

Review and JECME update
Caroline Sutton (Publisher/Co-Founder of Co-Action Publishing) provided an update on the JECME. She started by mentioning that the running of the journal is now co-ordinated by Co-Action Publishing, which publishes 34 journals across several disciplines, including Social Sciences and the Humanities, but primarily medicine. The publisher is committed to an open-access model that
ensures free access and re-use of articles. The new publisher is also committed to rapid publication, which means that the time from acceptance to publication in the Journal of European CME is now just 3–4 weeks. Anyone with an interest in CME is encouraged to submit articles to the journal.

Session 5: In conversation with Murray Kopelow

In this session, Murray Kopelow (President and CEO, Accreditation Council for Continuing Medical Education [ACCME], USA) conversed with key leaders in CME, discussing and exploring the topics that will impact on the future of CME in Europe.

Perspectives from Edwin Borman (UEMS-EACCME, UK)

The UEMS started accrediting activities within Europe in 2000 to provide a system for recognising participation in CME. At the time there was a recognition that while there was a high quantity of CME activities taking place in Europe, there was no standardisation or attempt to underpin the activities with regulation. There was also a recognition that some form of mutually recognised credit system was needed in Europe for people from different countries attending a multinational event. In this regard, the remit of the UEMS-EACCME is very much at an international level, and this was deliberate in order to avoid interfering with local accreditation systems in each country.

A major benefit of the UEMS-EACCME system is that it helped to harmonise CME across countries and raise standards. The introduction of UEMS-EACCME accreditation also provides a greater sense of certainty and purpose to CME in Europe.

In the first years, the number of UEMS-EACCME–accredited activities increased exponentially, but this is now starting to plateau. In recent years, Political, Economic, Socio-cultural, Technological, Legal and Environmental (PESTLE) factors have all impacted on CME in Europe. Taking the first of these factors, CME in Europe has become increasingly political. For example, the European Commission now references CME in several Directives, and national governments are starting to intervene more and more in the medical education process. Regarding the second of the factors, Europe – as with many other regions globally – has been experiencing a deep economic downturn. This means that there has been less money available for accreditation and CME activities. Looking at the third of these factors, from a socio-cultural perspective, the media in some countries are becoming increasingly interested in the relationship between the pharmaceutical industry and physician education – and this has been a key driving factor for increased transparency and regulation. Taking the fourth factor, technology continues to advance rapidly. The key is for providers to work out how to use the new technological advances within CME activities in a way that leads to more interesting and engaging education. Regarding the fifth factor – legal – there is a lot of new legislation and regulation currently being implemented that will have a major impact on CME in Europe, including the new EFPIA Code, as well as the US Physician Payment Sunshine Act. Finally, in terms of environmental factors, it should be an aspiration for everyone involved in CME to try to limit the environmental footprint of their activities.

Perspectives from Maureen Doyle-Scharff (Pfizer, USA)

There are currently significant financial challenges within the pharmaceutical industry, which means that there is now less money available to support CME activities. At the same time, the scrutiny of medical education activities that are supported by the pharmaceutical industry has increased substantially. In spite of these challenges, clearly it is the right thing for pharmaceutical companies to continue to support the education of HCPs. However, for this funding to take place, industry does need to consider and incorporate what is good for the company (in terms of being a maker of life saving medicines) as well as what is good for patients.

Importantly, the team at Pfizer does not determine how CME grants are spent and to whom they go. This is decided by a collective set of independent experts in education and clinical care, who debate and formulate a recommendation about a particular proposal based on its potential to change patient outcomes. However, while Pfizer independently gives money – and does not get involved in the actual content of accredited CME – the company is still a true supporter of change management with accredited providers. Along with stakeholders, and outside the context of accredited CME, request for proposals are written together that frame a gap in care that is important to both Pfizer and the society or ministry. From Pfizer’s perspective, the company is focused on good adult learning principles, and is specifically examining how it can help to change and improve systems in a measurable way. With this in mind, Doyle-Scharff does not believe that it is in patients’ interests for pharmaceutical companies to stop funding CME. This is particularly relevant for Pfizer given that the company uses a scientifically sound methodology to try to help improve healthcare systems and patient care.

Perspectives from Craig Campbell (Royal College of Physicians and Surgeons of Canada)

In Canada, the Royal College of Physicians was formed in the 1920s. However, it took until 2001 to launch a formal, mandatory CME system. The system is mandatory from the perspective that in order to maintain membership with the college (i.e. to remain a Fellow), then CME points need to be collected. However, membership in the college is voluntary.

The system in Canada was created to try to put physicians at the centre. In this regard, physicians took a leadership role in developing the accreditation system in collaboration with societies and other key stakeholders. Based on surveys, it is now clear that most physicians in
Session 6: Accreditation in focus

CME as a concept is taking hold in Europe, but there is still much discussion in relation to the rules of accreditation, including how it currently happens, and what the accrediting authorities want to see. In this session, leaders from several CME accreditation bodies discussed the lessons learned so far and where they see the future movement of accreditation in Europe. This included discussion surrounding the accreditation of CME activities in haematology, details of a project looking into rewarding higher levels of quality with additional CME points, and information on how changes in the CME environment are impacting on – and will impact on – learners, funders and providers.

EHA-CME, a body of accreditation in European haematology: from then to now – challenges ahead

Dimitris Loukopoulos (EHA, The Netherlands) gave an overview of how CME is accredited in haematology. Continuing educational activities such as annual congresses, master classes and workshops are offered by the EHA and other European haematological societies. The EHA-CME Unit accredits these types of CME as long as they are organised by academics without support from the pharmaceutical industry.

Participating in CME should be a moral obligation of the physician, for the benefit of him/herself and patients. Healthcare authorities also have a vested interest in encouraging doctors to undertake CME to ensure that patients receive the most up-to-date treatment. As part of this, and although there are differences across Europe, physicians are generally asked to spend around 50 hours per year on CME, with a focus on activities that improve performance and optimise patient care. To ensure this is time well spent, any CME activity must be of the highest quality, free from potential bias and ideally accredited by a recognised medical society or organisation. As a consequence, applications for accreditation of new CME activities through the EHA are subject to a rigorous review process to ensure principles such as independence, transparency and objectivity are adhered to.

However, Loukopoulos described how CME accreditation is not perfect, one major issue being related to how CME points are awarded. Currently, CME accreditation rewards the number of didactic hours spent at an activity, i.e. physical attendance at events. However, it is rare to carry out a quantitative evaluation of the impact of each type of CME on learning, an issue which may differ significantly between ‘important’ and ‘less important’ topics, between large conferences and small targeted meetings, between evidence-based guidelines and simple case reports, between ‘research’ and simply ‘didactic’ sessions. Additionally, still in most conferences, the ‘active’ participation of the audience cannot be confirmed in a satisfactory manner. Finally, there is little evaluation relating to whether the offered CME activity has changed the behaviour of the learner physicians. Although not currently included in the accreditation review process, a quantitative evaluation of the impact on learning in the future could help improve delivery methods of activities and to more fully determine whether CME contributes to changes in patient care.

Despite CME not being a mandatory requirement in many European countries, it should still be considered a must for all practising physicians to ensure the best possible treatment for patients – regardless of where they live. A mandatory CME system would ensure that physicians moving across Europe (especially in a south to north direction) will provide the same high level of care to all European citizens. To this effect, specialist societies providing CME accreditation, as well as UEMS, should not only persuade or oblige physicians to participate, but they should also offer this ‘tool’ to National Health Authorities.
which have much to gain from employing CME on behalf of their citizens. To encourage physicians to take part, societies in the future may consider awarding participants diplomas in recognition of their efforts, or offering symbolic awards such as travel grants or journal subscriptions. They can also lobby the authorities to reward physicians with consistent CME track records.

More CME points for higher quality
Since their introduction, most accreditation systems have focused on the independence of medical education, and have assumed that educational quality would be at least reasonable, mostly relying on the academic appointment and experience of the presenters. Evaluations over a broad range of participants as well as of CME/CPD modalities have shown that this assumption is by and large correct. In this regard, Reinhard Griebenow (European Cardiology Section Foundation, Germany) reported data from Germany, where >29,000 evaluation forms of live educational events have recently been assessed. This review found that CME activities were generally considered as highly relevant to the participants, with around 30% feeling that an event had helped them to consider implementing diagnostic and therapy changes. The majority of participants considered that their expectations had been met by attending a CME event and that the experience was rewarding.

In spite of this, it has become clear that the current practice of accreditation does not differentiate between fair quality and educational excellence. In this regard, the European Board for Accreditation in Cardiology (EBAC) has launched a new initiative to reward ‘More CME Points for Higher Quality’. The first project to benefit from this initiative has been a simulation course. In addition to normal criteria for allocating points, there will be an additional point for every part of the programme which has a total duration of 3 hours minimum with a practical exercise: theory ratio of 2:1 hours, and a tutor: participant ratio of 1:3. EBAC hopes that this new system will encourage providers to aspire towards excellence in CME delivery.

It is a time of change
According to Edwin Borman (UEMS-EACCME, UK), the last decade has seen a great shift in emphasis of CME from being a voluntary exercise to becoming a mandatory requirement. A UEMS survey showed that CME is now a mandatory legal requirement in 16 European countries and mandatory at a professional level in five countries (Table 3). Presently, it remains voluntary in just 14 countries. In addition to typical CME activities counting towards credits, some countries are now starting to recognise CPD activities such as communication, economic and legal skills within a learner’s broader portfolio.

The whole environment of national legislation around CME is starting to change based on what is happening in the US with the Physician Payment Sunshine Act and some countries are implementing changes into their own national laws. This will have wide-ranging repercussions. Learners will need to accept the increased transparency and accountability. Funders and providers of CME will most likely consider whether they wish to remain in this sector due to the increasing need to fulfil legal and regulatory requirements, and the difficulty in proving return on investment. Ultimately, some organisations may consider that the benefit/loss analysis is not in their favour. Others, however, may see this as an opportunity for growth and diversification through providing different models of education.

This time of change means there will be an opportunity to re-shape the CME sector, to put in place – by intention rather than by ‘evolutionary’ development – the standards, working practices, educational methods and strategic vision that are recognised as being necessary for the healthy development of the world of CME/CPD. And, in Europe, there is still the opportunity to retain within the sector, the responsibility for ensuring that appropriately high standards are achieved, without further intervention by law-makers. But, in order to do so, whether working together, or group by group, it will be necessary to implement improvements in a co-ordinated manner.

Much of that work already is underway. In this respect, organisations such as the Good CME Practice Group, EFPIA, the European Coordination Committee of Radiological, Electromedical and Healthcare IT Industry (COCIR) and Eucomed continue to be at the forefront of helping to deliver core principles and standards for CME. This is a time of change but should be seen as an opportunity for all stakeholders to work together collectively to create a better system of CME.

Lunch with the learners
Session 6 of the meeting was followed by a lunchtime forum that was chaired by Lawrence Sherman (Prova Education, USA), who led a discussion with Mathena Pavan, a UK specialist registrar in gastroenterology and Krzysztof Jakubowski, a UK General Practitioner (GP).

| Requirement       | Country                                                                 |
|-------------------|-------------------------------------------------------------------------|
| Mandatory legal   | Austria, Czech Republic, France, Germany, Greece, Hungary, Ireland, Italy, Netherlands, Norway, Poland, Romania, Slovakia, Slovenia, Croatia, Switzerland |
| Mandatory – professional | Germany, Italy, Netherlands, Switzerland, United Kingdom       |
| Voluntary         | Belgium, Bulgaria, Cyprus, Denmark, Finland, Greece, Iceland, Luxembourg, Malta, Norway, Portugal, Spain, Sweden, Turkey |
| Re-certification  | Croatia, Hungary, Netherlands, Norway, Slovenia                        |
| Re-licensing      | Croatia, Hungary, Ireland, Netherlands                                |
As with the same session at the previous meeting in 2012, this was a popular, engaging format that explored the opinions of the two learners on educational programmes in general, and that also enabled the audience to gain the insights from the learners into their personal experiences with CME. From both of these learners’ perspectives, it was clear that CME is now becoming much more important in the UK due to the need for mandatory revalidation. However, in spite of this increased pressure, both of the learners agreed on the importance of CME for raising professional standards. Interestingly, both learners also agreed that their choice of CME is not influenced by industry sponsorship. However, if the activity turns out to be biased, then the learners will ignore the educational content.

Jakubowski observed that from the GP’s perspective, one of the most difficult issues relating to CME is how to decide on personal educational needs — particularly given the number of conditions that a GP sees — and then to determine the most appropriate CME activities to meet these needs. Information on CME activities is gained from the internet and the Royal College of General Practitioners. In deciding on an activity, the most important criteria are in relation to quality. However, this can sometimes be difficult to judge in advance. Other major issues relating to CME for the GP were down to cost and finding time to learn due to a busy workload.

Pavan speaking from the specialist’s point of view, described a key concern. She stated that the number of CME activities available seem to be linked to conditions that can be treated by expensive new drugs (i.e. where there is funding). However, there is a paucity of activities in areas where there are no drugs available. Consequently, there is a fundamental bias and there is a need to be able to access a broader range of education. She also mentioned that it is difficult to ascertain the quality of an event before attending. From a financial perspective, there is some money assigned to each specialist in the UK to enable learning. However, any kind of interventional training (e.g. endoscopy courses) is much more expensive than lectures, which can be a disincentive to attend this important type of learning.

Session 7: CME quality and compliance challenge

For this session, delegates were invited to act as providers to pit their wits against a panel of ‘CME investors’, consisting of five experts from across the spectrum — a CME accreditation body, represented by Reinhard Griebenow (ECFS, Germany), an education expert — Jonas Nordquist (Karolinska Institutet, Sweden), an experienced Scientific Director/Chair — Peter Mills (The Royal London Hospital, UK), a learner — Krzysztof Jakubowski (GP, UK), and a pharmaceutical company supporter — Maria Grazia Cali (Merck Serono, Germany).

Providers were ask to present ideas for activities that would be focused on meeting the educational needs of learners while maximising audience interest, that would be educationally well executed, that would be attractive to a supporter from industry, and that would be compliant under CME accreditation rules, regulatory and legal requirements. Overall, four providers presented a wide range of hypothetical project ideas. The panel was able to guide and criticise the presenters, assessing how well each project met their specific needs and regulations, with help from the audience. The session essentially provided an opportunity to reiterate and examine the key fundamentals of how to put good CME into practice that was started during Session 1 of the meeting, and explored in other sessions.

Session 8: The CME unsession

The final session of the meeting was an unbrieved and unpreconceived session led by Lawrence Sherman (SVP Strategic Education, Prova Education, US), with the aim of helping to make sure that no one left the meeting room with any question still in his or her own mind. The main topic of conversation in this session related to the impact of the US Physician Payment Sunshine Act on CME in Europe.

It was confirmed that ACCME-accredited providers are excluded from having to declare transfers of value. However, most major congresses in Europe are not accredited for US CME credits. Consequently, the US Physician Payment Sunshine Act could have a major impact on meetings in Europe, and the unintended consequences may be significant. It was felt that the Physician Payment Sunshine Act would have a considerable impact on any activities in Europe that included delegates or faculty from the US, as they would be increasingly concerned about participating in activities in Europe. This would impact on faculty selection, as well as meeting delegates. This led to a discussion about grants and sponsorship and the need for European scientific societies to stipulate in detail how money will be spent, before financial support can be given.

Summary

The Sixth Annual Meeting of the European CME Forum involved lively debate among the 100 or so delegates who gathered from across Europe and throughout the world to discuss issues such as the how to ensure best practice and improve the quality of CME programmes, and the role of various stakeholders such as medical societies and industry in CME. The meeting featured presentations that showcased innovative e-learning activities and included discussions relating to the latest legal and regulatory frameworks that are impacting on CME activities in Europe.

The 7th annual meeting will take place in London 12–14 November 2014.

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