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Current perspective

Continuing medical education in Europe: Towards a harmonised system

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ABSTRACT

One of the first reports on the state of medical education was published in 1910 in North America, with the support of the Carnegie Foundation, showing that the interest for this issue dates back at least a century. Doctors (and nurses) are among the few professionals who managed to avoid for a long time any sort of evaluation of their knowledge and competence after the achievement of their diploma. But concern has been rising in society about the fast obsolescence of medical knowledge, particularly in the last 50 years when the development of research and technology in the field has been so fast. The concept of Continuing Medical Education gained growing interest after the Second World War as a necessity for health professionals, but also as a form of protection of patients, who have the right to be treated by competent and knowledgeable doctors and nurses. The United States (US)-based Josiah Macy Foundation recently sponsored a conference exploring the state of continuing education and the result is 'a picture of a disorganised system of education with obvious foci of excellence (most in universities) but with most commercially supported events shading more towards product promotion and the welfare of doctors than prioritised dedication to enhancing the care of patients'.[1]

Despite the fact that there is a lot to be learned from the US experience, Europe has to find its own way. Considerable progress was made since 1995 when UEMS (Union Européenne des Médecins Spécialistes) started to structure CME activities in Europe at translational level. A workshop on the issue was jointly organised by the European School of Oncology (ESO) and the Accreditation Council of Oncology in Europe (ACOE) in Berlin in September 2009.

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The United States (US) experience with continuing medical education (CME)

Alejandro Aparicio, MD, FACP, American Medical Association

A formal system of continuing medical education (CME) and CME credits began in the United States in 1948 when the then American Academy of General Practice, now the American Academy of Family Physicians (AAFP), Prescribed and Elective Credit System was instituted. In 1968, the American Medical Association (AMA) developed the Physician's Recognition Award (PRA) to acknowledge and encourage physicians that dedicated 50 h a year to CME. The AMA PRA credit system, with *AMA PRA Category 1 Credit*™ and *AMA PRA Category 2*™, was developed to support that effort. In 1972, the American Osteopathic Association (AOA) created a CME credit system to serve the needs of osteopathic physicians.

While the AAFP and AOA systems are designed to meet the educational needs of two specific groups of physicians, the AMA system is not speciality specific. All three credit systems are similar in their educational philosophy and educational activity requirements and have a strong collaborative relationship. CME credits from all three systems are recognised and accepted by organisations that require physicians to participate in CME as part of their requirements such as licensing boards, specialty boards, hospitals and others. All three systems also have a process to recognise the credits from the other two systems.

The three systems were started voluntarily by physician groups and as a result of the desire on the part of the profession to meet an educational need, which became recognised as a professional responsibility and is now accepted as an ethical imperative within the profession. Over time, other groups have come to appreciate the profession's wisdom in developing these systems and have began requiring CME credits for specific purposes such as licensing, specialty board certification and hospital privileges.

One strength of the overall system rests on its diversity. Providers of CME can be national, regional, state or local organisations and can therefore focus on the educational needs of their learners in all these different environments. In addition, the organisations that develop CME activities can be hospitals, medical schools, specialty societies, government agencies and others and are therefore able to develop their activities from different perspectives.

Other strengths includes the close working relationship among the credit systems, the acceptance of the credit systems by multiple entities, including governmental ones, standardised methods to award credit and a growing research literature demonstrating the value of CME in improving knowledge, skills, professional performance and patient outcomes. But the major strength has been the willingness of the credit systems to evolve and find ways to recognise the learning that physicians engage in while in a variety of activities, beyond conferences and reading materials, to include those that are more individual in nature, such as reviewing manuscripts submitted for publication and others that are based on patient care data such as Performance Improvement CME activities.

A major debate is taking place within the profession and also in the public arena regarding the role of industry in physician education. Unquestionably, there is no place for commercial bias in CME activities but there is a debate as to whether commercial support can be received without it resulting in commercial bias being introduced. Some argue that even if it is possible to receive commercial support without introducing bias, the appearances to the public may make this undesirable anyway. This issue is often confused and intermingled with the issue of personal conflicts of interest on the part of CME faculty or the activity organiser, as a result of financial relationships with industry, as well as other practices including industry support for research. The issue has not been resolved yet and all the questions have not been answered. However, the discussion and dialogue continues and with it the awareness of the issues increases.

Overview of the situation in the 27 EU Member States

Françoise Van Hemelryck, ECCO Education & EU Project Manager

At present, there are no standard rules in Europe for continuing medical education (CME). The European Union does not act on CME rules as the subsidiarity principle prevails in this area.

A recent survey performed by ACOE – the European Accreditation Council of Oncology in Europe – demonstrates the heterogeneity of the situation between EU countries. The heterogeneity concerns different aspects including the compulsory character of CME, the CME rules and practices as well as the ways in which CME is implemented and organised.

A number of EU Member States have established compulsory CME with a legal obligation to collect CME credits. This is at present the case for 17 countries out of the 27 EU Member States. Nevertheless, many countries where CME is voluntary do have guidelines recommending health professionals to participate in CME activities.

The number of CME credits to be collected also varies greatly from one country to the other in all the geographical parts of Europe. The general trend is to collect 50 credits/year. In the CME mandatory countries, the most demanding requirements are in Bulgaria with 150 credits/year and the least in Slovenia with 10.7 credits/year.

Heterogeneity also lies in the way CME authorities are structured. CME authorities are recognised as competent in CME in each country. Very often these authorities are national medical associations/chambers working closely with scientific societies/academies and sometimes medical schools. Their roles and responsibilities in CME differ from one country to another and may include proposing or issuing laws and/or guidelines on CME; promoting CME; issuing certificates to health professionals and managing the accreditation system for CME events and/or organisers.

In most countries, CME events are accredited on a case by case basis, in some countries including Austria, France, Slovenia and more recently Italy, CME providers are accredited for a fixed period of time.

To facilitate the recognition of CME credits awarded to doctors attending events outside their home country by the CME

authorities within their home state, the *European Union of Medical Specialists (UEMS)* set up in January 2000 a clearing-house system for CME credits – the European Accreditation Council for Continuing Medical Education (EACCME).

More than two-thirds of the EU countries participate in this system including countries where CME is not mandatory. Participating in the UEMS-EACCME system means that the authority automatically accepts the validity of the credits obtained by national health professionals through their participation in UEMS-EACCME accredited events outside their own country.

There are also significant disparities between EU countries on the types of CME activities that are valid to collect CME credits. Apart from the traditional CME congresses and conferences, other types of activities include peer review, acting as a moderator or speaker at a CME event, reading CME literature, visitations, writing a scientific paper and CME e-learning. E-learning is currently accepted in 15 of 27EU countries.

*Detailed information about the outcome of the survey can be found on the ACOE website (www.acoe.be).

The role and future programmes of UEMS

Bernard Maillet, MD, Secretary-General UEMS-EACCME

The CME/CPD needs and the way it has to be organised are duties of the National Accreditation Authority (NAA) 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 format 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 have also a certain role to play in the whole picture of the CME/CPD of a (specialist) doctor.

UEMS has started the European Accreditation Council on CME (EACCME®) in order to help the European Medical Specialists 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. This was the start of the EACCME® where we proposed to have a clearing house where requests for European Accreditation could be sent to.

Following the formalisation of agreements between UEMS-EACCME and the European Board of Accreditation in Cardiology (EBAC) in 2008, with the European Board of Accreditation in Pneumology (EBAP) in 2009, and the closer cooperation with other European Specialty Accreditation Boards (ESABs), it is becoming apparent that each has their own individual requirements. To discuss these further and to develop means of co-operation and harmonisation of procedures, a broad Working Group across the ESABs and competent bodies has been convened this year, thanks to the Accreditation Council of Oncology in Europe (ACOE) in order to achieve clarity of purpose and close co-operation. We also look forward to positive outcomes from this initiative.

Obviously, if every country and all the different specialties have their own CME–CPD systems and processes, this will not improve the exchange and mutual recognition of the credits allocated to the activities and events and therefore, harmonisation is needed going through a common pathway.

Translation table for credits

The different credit systems used worldwide have in one way or another a link with the time spent at the activity or event and is based on the hour (or a fraction of it).

When the EACCME was running we proposed to introduce the European CME Credits based on a very simple and transparent system: one European CME Credit (ECMEC) per hour of activity with a maximum of three ECMECs for a half day and six ECMECs for a full day activity.

Following an initiative proposed by the late Dr. Helios Pardell, we formalised a type of CME currency exchange rate between the ECMECs and Spanish credits, incorporating it into the agreement between UEMS-EACCME and the Spanish Accreditation Council for CME (SACCME), where 1 ECMEC equals 0.12 SACCME Credits. We are now taking this work further and creating a translation table of participating National Accreditation Authority (NAA) credit systems and their reciprocal values within the ECMEC system. This clarification is important in order to avoid confusion: the UEMS office is frequently approached with questions about the value of National Credits and the ECMEC equivalent. A similar procedure will need to be put in place concerning the recognition of AMA PRA Category 1 Credits for European physicians attending activities in the USA.

The Accreditation Council of Oncology in Europe (ACOE)

Jan. W.H. Leer, MD PhD, ACOE Chairman
Dieter. K. Hossfeld, MD, former ACOE chairman

Given the competences of the national CME authorities to create their own CME rules, the question for the oncology community was how to create a system which avoided the situation where organisers of a multidisciplinary and international oncology event have to ask approval from all the different scientific societies and national authorities. This was extensively discussed within FECS, as the forerunner of ECCO – the European CanCer Organisation, the platform of the major European oncological societies. The result was the creation of the Accreditation Council of Oncology in Europe (ACOE) created in 1999 as an independent ECCO Committee which along the lines of certain rules could accredit oncological activities with a certain number of CME points.

The first challenge was to find a solution on how to get the national authorities accepting the role of ACOE. To use the UEMS network was thought to be too bureaucratic, too costly and the participation of the national authorities in the system at that time was not convincing. However, this changed over time. ACOE now accredits oncological activities based on the professional content, and UEMS is the linking pin towards the national authorities to have these accreditations accepted in national systems. Doctors are now aware that they increasingly need these points for their re-registration, so ACOE is a necessity for doctors active in oncology all over Europe. Providers of meetings need ACOE

to have their meeting accredited because, if not, they will not attract sufficient participants. Increasingly commercial congress organisers and (pharmaceutical) companies enter the congress market and provide meetings and symposia. ACOE believes that it has to check carefully whether such events are not influenced by commercial interests and speakers are not used as salesman for a certain product. To find the right balance in this matter is the focus of ACOE in the present time, as well as the criteria for the accreditation of e-learning materials.

The European School of Oncology: a 28 year experience of Continuing Medical Education in cancer medicine

Wolfgang Gatzemeier, MD, Breast Surgeon, ESO Masterclass programme coordinator

Since the inception in 1982, ESO dedicated itself towards the fight against cancer, first and foremost by optimising the training and updating the knowledge of those physicians and other health providers dealing with cancer patients. The mission is reflected in its motto 'Learning to care', which stresses the concept of studying, learning and also caring for patients in a global sense.[2] ESO's goal of contributing to the reduction of deaths from cancer due to late diagnosis and/or inadequate treatment and in shortening the time needed to transfer knowledge from research centres to daily practice has been considerably achieved during the last decades. Nevertheless, ESO is expanding and upgrading its educational instruments (Inside Track Conferences, Advanced Courses, Seminars and Symposia, Training Courses, e-learning and last but not the least the Masterclasses as the supreme educational programme) challenging the fight against cancer in an active and innovative way (http://www.eso.net/).

In addition to fostering the harmonisation of a common CME system in Europe, ESO designed and organised a first European Conference on CME in Oncology in collaboration with the University College Dublin and with the financial support of the European Commission (Europe Against Cancer Programme).[3] This conference was held on 12th and 13th October 1995 in Dublin, Ireland and agreement was reached on the following statements: CME is an ethical duty and an individual responsibility. A common concept and system within a CME framework may have a considerable impact on EU integration (scientific and cultural interchange among Member States). A credit system is needed to keep track of CME activities and credit transfer among Member States is vital to facilitate exchange between Member States.

The challenge of e-learning

Alberto Costa, MD, Director European School of Oncology

Distance learning came as a response to the educational needs of people working in different professional fields, willing to improve their knowledge and competence but unable to physically follow specific courses in schools and universities because of distance or financial restraints. The Open University in the United Kingdom is probably one of the most respectful examples of the efforts made in this field and of the brilliant educational results obtainable with distance learning. This methodology includes the sending of learning material to students, mail and/or telephone assistance by tutors, evaluation tests, teaching feedback and learning assessment tests. The great revolution came with the availability of the Internet, which suddenly simplified dramatically communication all over the world at virtually no cost. By the term e-learning we now define any sort of knowledge acquisition through the Internet, an enormous potential for educating unexpectedly high numbers of professionals avoiding travel and accommodation costs and giving a chance of improvement to people living very far from traditional educational sites or being confronted with very demanding jobs that can leave very little time to study. Of course e-learning will never replace the physical interaction with the teacher, the cross fertilisation with the other students and most importantly the acquisition of clinical competence and skills which require the direct contact with the patient. However, a lot can be achieved with these new modern methodologies and all participants in the workshop wished a further engagement of UEMS in the field. The provocative proposal of granting even more credits to e-learning (1 h = 2 credits?) was also put forward.

Conclusions

The ESO-ACOE workshop on CME reaffirmed the importance of CME stressing the fact that the quality of patients care is deeply affected by the up to date knowledge of health professionals. The participants welcome all efforts aiming to move from traditional learning to behavioural changes and underline the need to improve the evaluation of effects of CME rather than just checking the presence of students in classrooms. Not only control and sanctions should be identified by the relevant authorities but also support and encouragement should be given to those honestly willing to improve their competence and skills. Ethical aspects of funding of CME were also addressed and e-learning was proposed as an extraordinary opportunity to reach the ambitious goal of a constant update of health professionals.

A follow-up meeting was announced on the occasion of the ECCO 16 – ESMO 36 Congress in Stockholm on 23–27 September 2011.

List of faculty and participants of the Berlin workshop can be found on the ACOE website (www.acoe.be).

Conflict of interest statement

None declared.

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