Conference Insights

2nd Annual Meeting of the European CME Forum

in-depth report from a meeting held in London, UK, 18–19 November 2009

by Eugene Pozniak and David Williams
Executive summary

Shaping the future for continuing medical education (CME) in Europe is bedevilled by many challenges. Mindful of the mantra that ‘when America sneezes, Europe catches a cold’, European healthcare stakeholders can, and must, learn from mistakes made in the USA when developing a robust framework for CME in the region. The 2nd Annual Meeting of the European CME Forum drew together many of the influential players from Europe and beyond who hold the key to the development of CME in Europe. Interactive discussion focused on the major issues determining progress: education-needs analysis, CME accreditation, evaluating and improving outcomes, the role of both the pharmaceutical industry and the patient, and setting and maintaining standards. Sessions also examined the evolution of learning and the impact of technology.

The role of the pharmaceutical industry appears central to the conundrum. CME without industry support is impossible – but pharma needs to increase its engagement with CME and to understand how it can be used to help provide greater value to its customers. Industry involvement in CME must go beyond that of a commercial organisation. To progress, pharma’s role must not be reduced solely to sponsorship to drive sales. Companies should instead take on greater responsibilities as educators.

CME is about ensuring that physicians are fit for purpose and to reassure patients that those physicians are able to manage the lifetime of their disease. Critics claim that the current structure of CME in Europe does not provide that reassurance and lacks the intellectual rigour, organisation and funding to succeed. The 2nd Annual Meeting of the European CME Forum explored strategies to improve CME across Europe: from needs analysis and programme accreditation, through funding, methodology and transparency, to implementation and evaluation. This Conference Insights report provides a concise summary of the salient issues.
2nd Annual Meeting of the European CME Forum
Programme director: Eugene Pozniak, Siyemi Learning, London, UK, 18–19 November 2009

Day one
Welcome address
Eugene Pozniak (Programme Director, European CME Forum)

Assessing our own educational needs
Lawrence Sherman (SVP Educational Strategy, Prova Education)

Session 1: Assessing educational needs and setting learning objectives
Chair: Thomas Kellner (Global Leader Medical Education, MSD)
Good CME/CPD: why needs assessment becomes an essential element
Thomas Kellner (MSD)
Meeting educational needs through CME – the learner’s perspective
Sue Guthrie (Scientific Director, The Oxford Academy for Professional Health Education)
The challenges of meeting the educational needs of physicians through CME
Hervé Maisonneuve (Associate Professor of Public Health, Université Paris-Sud 11, France)
The assessment of general practitioners’ needs: an underestimated area in the current CPD-programmes?
Peter Posel (CEO, QUAIME, Switzerland)
Evaluation of an online Diabetes Needs Assessment Tool (DNAT) for health professionals: a randomised controlled trial
Sara Schroter (Senior Researcher, BMJ)

Session 2: CME plugged in
Chair: Edwin Borman (Chair, UEMS-EACCME Taskforce)
Achieving the LEARNING in e-learning
Cally Fawcett (Head, Delta Kn, UK)
Impact of eCME on clinical practice
Jörg Ansorg (CEO, Professional Board of Surgeons, Germany)
Accreditation can improve the quality of e-learning
Edwin Borman (UEMS-EACCME Taskforce)

Session 3: CME unplugged
Panellists: Vladimir Finsterle (CEO, Pears Health Cyber, Czech Republic), Saurabh Jain (Director CME Solutions, Indegene, India), Alfonso Negri (Technical-Scientific Secretary, Italian Federation of Scientific Medical Societies), Lawrence Sherman (SVP Educational Strategy, Prova Education), Lisa Sullivan (Managing Director, In Vivo Communications, Singapore)

Day two
Session 4: Quality standards and controls
Chair: Robin Stevenson (President, EBAP)
Panellists: Maureen Doyle-Scharff (Senior Director, Medical Education Group, Pfizer), Thomas Kleinseeder (Chief Medical Officer, KWHC, Germany), Bernard Maillet (Secretary General, UEMS-EACCME), Archie Prentice (Chairman, CME Committee, European Hematology Association)

Session 5: Measuring outcomes in CME
Chair: Wolfgang Grisold (Chairman, UEMS Neurology Board and Section)
CME/CPD introduction
Wolfgang Grisold (UEMS Neurology Board and Section)
Outcome-based evaluation
Abi Sriharan (Director, International Continuing Health Education Collaborative, University of Toronto)
Is there a place for patient associations to influence doctors’ education?
Alexandre Bisdorf (President Elect, UEMS European Board of Neurology)

Session 6: Learner and industry relationships with UK and European CME/CPD
Chair: Ian Starke (Director of CPD, Royal Colleges of Physicians)
Panellists: Thomas Kellner (Global Leader Medical Education, MSD), Bernard Maillet (Secretary General, UEMS-EACCME), Andrew Powrie-Smith (Director, ABPI Scotland)

Session 7: The CME unsession
Lawrence Sherman (SVP Educational Strategy, Prova Education)

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Introduction

The 2nd Annual Meeting of the European CME Forum was held in London in November 2009, following a successful inaugural meeting in 2008. The Forum aims to bring together the stakeholders of European continuing medical education (CME).

The two-day meeting maintained much of the 2008 structure, addressing a wide range of topics with a practical application or relevance to CME in Europe. Minor format revisions in 2009 allowed speakers more time to address their topics of interest and made greater provision for discussion following each presentation. In addition, there was extensive use of interactive technology, with continuous access to an audience response system. The pre-meeting use of Twitter also played a part during the Forum.

The added flexibility to the structure of the meeting gave speakers and delegates the opportunity to pose additional questions for more in-depth discussion, such as the role of the patient, the suitability of social media and the involvement of industry, and allowed free discussion of accreditation review practices and requirements. With the additional interest in the Good CME Practice Group, there were many indicators that there is much to discuss in the European CME sphere which will help to drive the formulation of future meetings.

About the authors

Eugene Pozniak is Programme Director of the European CME Forum and also Managing Director of Siyemi Learning, an independent European CME provider. He has worked in the medical sector for over 20 years. Following a degree in chemistry he initially worked across various functions in marketing and medical communications. Since 2000 he has been working exclusively in CME. As well as giving advice on CME matters and managing CME-accredited meetings, Eugene developed the first pan-European CME-accredited e-learning (launched in 2002) and continues to work on national and internationally accredited e-learning.

In 2006, Eugene founded Siyemi Learning, which also supports the European CME-CPD Academy, an independent platform for accredited e-learning in Europe. In 2008, he partnered with Peter Llewellyn of NetworkPharma to create the European CME Forum.

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David Williams pursued a career in the pharmaceutical industry for 12 years before joining the medical communications sector in 1989 to deliver educational and training multimedia programmes to clinicians, nurses and other health professionals on behalf of the UK Department of Health and Central Office of Information. Subsequently, and working as part of the Healthworld global business group, David developed a number of early intervention strategic solutions to support the commercialisation process within the international pharmaceutical sector.

David then progressed to collaborate with medical and clinical associations, societies, colleges and accreditation authorities internationally to develop and deliver fair, balanced, unbiased and independent accredited events and on-line programmes in support of medical continuing professional development. David is now owner and managing director of 3C Strategy Limited, an independent communications and CME consultancy. Since becoming a consultant to the industry, David has been engaged in reviewing the medical communications sector across the whole of Europe and is currently occupied developing models for the assessment of effectiveness of medical education (CME) and its impact on day-to-day medical practice.

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The European CME Forum is committed to making CME greener by helping to reduce the burden on the environment when carrying out its work.
The 2nd Annual Meeting of the European CME Forum was opened by Programme Director, Eugene Pozniak, who gave a brief overview about the changing nature of CME in Europe. He described how CME is moving away from the private province of healthcare professionals to a more public arena where there is increasing interest, not just from potential financial supporters, but also from other groups such as regulatory bodies, governments and patient groups. He observed that this is expected to increase in the coming years as continuing professional development (CPD) in all professions – even lorry driving! – gathers apace in Europe. The aim of the European CME Forum is to bring together the stakeholders of European CME at meetings such as this to continue dialogue in this important area.

Assessing our own educational needs

A warm-up session to the meeting, led by Lawrence Sherman (Prova Education), helped to demonstrate a key principle of CME: assessing the educational needs of learners. Sherman examined the audience’s current levels of knowledge and expectations in an attempt to establish why people had attended the meeting. He pointed out that while evaluations from previous meetings and the faculty’s thoughts about what a meeting should cover are important, meetings can end up being meaningless unless they address the needs of the audience in the room.

Meetings can end up being meaningless unless they address the needs of the audience in the room

Sherman asked for contributions from the audience to elicit views on the planned programme. A variety of issues were raised and Sherman guided delegates to the sessions likely to address them, emphasising the importance of interacting with faculty during the sessions so as to maximise the opportunity of understanding the topics being addressed.

Sherman also discussed the use of ARS (audience response systems). He recognised that ARS are used to capitalise on the ‘anonymity factor’, and suggested that they provide honest feedback whilst engaging with the audience and monitoring their progress in decision-making during the session. The downside of ARS was identified as the lack of an appropriate faculty response: all too often speakers acknowledge responses brought to the screen via ARS but then move on without any further comment or discussion. This does not take advantage of the teachable moment from the slide.

Whilst then discussing guidelines and the awareness, or lack of it, in the wider community, a question was raised regarding the low percentage of commercial supporters of CME – the pharmaceutical industry – at the meeting. It was widely agreed that the majority of pharma personnel do not understand CME and are constantly asking for support with their CME activities. Reasons given were threefold:

1. “It’s not my responsibility…” – this suggests that pharma does not know where CME sits in its portfolio of opportunities. Since it is neither a marketing nor a clinical function, there is often no department or single person responsible for managing CME within pharma.

2. CME demands long-term commitment and relationships. Individuals in pharmaceutical companies do not consider themselves to be an active and connected partner in CME.

3. Time, financial commitments and nervousness about European CME. There is a consensus that CME is confusing and many in the industry have decided to step back to let the European CME community sort everything out first before they join in.

Some members of the pharmaceutical industry responded; one admitted that there is confusion regarding CME matters while another pointed out that companies had their own vested interest in what they are doing. It was also suggested that, unfortunately, the pharma industry, in its worst form, tended to think promotionally all the time and was focused on short-term gain. The aims of CME are to understand doctors’ needs and to develop high-quality but impartial educational programmes.

Faculty should be prepared to amend their programmes to address responses to questions raised during the sessions

Sherman returned to the specific needs of the people in the room. Content may be created well in advance of a meeting and in response to needs analysis carried out in the wider community, but faculty should be prepared
to amend their programmes to address responses to questions raised during the sessions.

A question was asked about the role of the patient in CME. Ninety per cent of delegates thought that there was a role for patients in CME. Case-based education was a good example of actual cases (patients) being used within CME. In addition, patient blogs are in some cases tracked as part of determining needs, as well as with the aim of obtaining closer liaison with patient groups.

Finally, it was asked whether social media had a role in CME. Twitter, LinkedIn and Facebook were all cited as business tools, whereas clinical-based forums were identified as good ‘consulting rooms’ in which a proposed CME programme can be commented upon by its potential target audience.

Assessing educational needs and setting learning objectives

Good CME/CPD: why needs assessment becomes an essential element

Thomas Kellner (MSD), who chaired the first session of the meeting, began proceedings by putting a series of questions to the audience about methods of needs assessment. He asked whether people engaged with expert faculty or learners, and whether needs assessment should be a mandatory part of programme planning. This is not current practice in Europe. In addition to this, most practitioners in Europe currently perform their own self-assessment of learning needs. This works with well-educated doctors, as they are aware of their own knowledge gaps, but does not work as well with less well-educated doctors as “you don’t know what you don’t know”!

Kellner went on to say that, in general, two types of needs assessment can be considered:

1. At a strategic level – this allows long-term planning of learning curricula.
2. When programme and content planning – this requires knowledge of the target audience, needs assessment and gap analysis of learners.

The challenges of meeting the educational needs of physicians through CME

Hervé Maisonneuve (Université Paris-Sud 11) began by examining the current state of needs assessment in France. In the case of planning events, needs assessment is applied in few cases and, even then, it is difficult to achieve meaningful results. Needs assessment is often carried out from the perspective of the stakeholders (e.g. insurers) who, in France, are pushing the system in those topics that are clearly oriented toward creating financial savings in the medical system. Where, he asked, are the interests of doctors and patients in all of this?

Questions put to the audience addressed the use of needs assessment in Europe. Most thought that there was room for improvement. One example given from the floor explained that most education is based on medical and scientific needs and not on the management, communication and other types of needs that are equally as important in the making of a rounded and well-educated doctor. In response, Wolfgang Grisold (UEMS Neurology Board and Section) agreed, saying that, particularly at large congresses and meetings, the educational sessions are decided by scientific committees.

Following further discussion, it soon became apparent that a variety of methods are used across Europe for assessing needs and that each assessor has no idea what methods other assessors are using or what is common practice.

In summary, Maisonneuve reflected that physicians in Europe are trained to a specific curriculum within their own specialties, but that no curriculum exists for CPD. He asked the audience whether a CPD curriculum should be established for each specialty. The general feeling amongst delegates was that mandatory curricula might not be relevant for the learner as many physicians practice in very different environments. It should be learning for the learner, not learning for some other body, that determines the curriculum.

Meeting educational needs through CME – the learner’s perspective

Needs assessment is regarded as best practice, but no best practice for undertaking the needs assessment process currently exists. Many different methodologies are used, depending upon the stakeholder, but traditionally it is accepted that the needs assessment will inform the activity. Both the European Accreditation Council for CME (EACCME) and the Accreditation Council for Continuing Medical Education (ACCME) guidance mandate a needs assessment for accreditation, but neither agency offers further advice on exactly what that needs assessment should include.

An online survey was developed to explore learners’ attitudes and preferences with respect to needs assessment, and also to evaluate CME/CPD activities. Sue Guthrie (The Oxford Academy for Professional Health Education) presented findings from the survey, a link to
which had been sent to more than 1000 international healthcare professionals covering both primary care and specialist medicine.

Although the proportion of respondents was low (4%), the survey confirmed many of the important aspects of CME from a physician’s point of view. Content was seen to be the most important aspect when deciding whether to participate and most respondents would expect to learn something new from a CME activity rather than use it to reinforce current practice.

Respondents felt that their own learning needs should be informed by their peers and ‘expert’ physicians within their specialism. They were less interested in senior colleagues, patients/carers and policy makers setting the agenda. Perhaps most interesting was the link between needs assessment and outcome measurement: about one-third (30%) of respondents considered the evaluation process not to be important (Figure 1). Guthrie said that this is a matter for concern and worthy of further investigation.

One participant challenged the validity of these data, suggesting that since only 33 people (4%) participated, no statistically meaningful conclusions could be drawn. Guthrie acknowledged this and said that the survey is being used to inform future exploration and research into the issues and topics being addressed.

The assessment of general practitioners’ needs: an underestimated area in current CPD-programmes?

Peter Posel (QUAIME) presented results from a study of GPs in Germany and the Czech Republic. The study examined how communication and performance needs were addressed, in addition to pure medical education needs. He explained that there should be a regular pathway to ensure that every programme has a needs assessment. Based on the needs assessment, the learning objectives can then be clearly defined. These two elements can take up to 25% of the total time needed to develop a programme.

Posel went on to describe four steps by which real and sophisticated data can be obtained from a needs assessment:

- Step 1 – establish confidence with long-term relationships with the target groups
- Step 2 – understand the activities of the target groups
- Step 3 – know the specific attitudes and work styles of the target group; involve official GP bodies in this process
- Step 4 – keep the target group involved but maintain anonymity: there must be total separation between needs assessment results and other comments.

Time is the issue and so the personal and environmental attitudes of the target group need to be considered when sending out needs assessment questionnaires. For example, Friday has proven to be the most effective day for despatching questionnaires, leading to higher response rates.

The assessment of GPs’ needs is an underestimated area in current CPD programmes

Posel outlined the background to a GP needs assessment study that linked diabetes to depression and included
CME largely relies on self-directed learning – i.e. individuals’ perceived learning priorities and opportunities. But evidence suggests that people’s ability to self-assess is very limited, particularly those who are the least competent. Sara Schroter (BMJ Group) introduced her presentation by pointing out that while many diabetes educational programmes are available, few have been assessed in a systematic manner, and that there was a need to develop methods to evaluate the effectiveness of the dissemination and understanding of clinical guidelines.

Schroter presented the aims of a study, developed by BMJ Group in collaboration with Cardiff University and MSD, that assessed the effectiveness of a new online Diabetes Needs Assessment Tool (DNAT) on health professionals’ knowledge of diabetes and its management. The aim was to evaluate the acceptability of this process and to measure changes in clinical practice as a result of the learning. Participants were from the UK and Germany, and a comparison was made between these two countries.

Schroter described how the participants were randomised to undergo a 4-month learning period where they were given access to diabetes learning modules alone (control group) or to the DNAT plus the diabetes learning modules (intervention group). The effect of the needs assessment tool on health professionals’ knowledge of diabetes and its management was assessed, as was the acceptability of this process of learning and any resultant changes in clinical practice.

CME plugged in

This session addressed the increasing importance of CME-accredited e-learning in European CME. Chaired by Edwin Borman (UEMS-EACCME), the panel considered best practice in online education and looked at how e-learning can impact day-to-day practice.

Evaluation of an online Diabetes Needs Assessment Tool for health professionals: a randomised controlled trial

Cally Fawcett (DeltaKn, UK) ran a workshop about understanding how people learn and how, subsequently, to apply this knowledge to the development of good learning content. She asked delegates to complete a worksheet (see Figure 2).

Fawcett described this as a very simple learning styles test. Known as the VAK (Visual, Auditory, Kinaesthetic) test, it is based on the simple idea that everybody uses some of their senses – sight, hearing, touch – and their feelings to learn. e-learning offers the opportunity for all these factors to be fully engaged.

Fawcett observed that it had been interesting listening to discussions at the meeting about adult education, and that people were interested and knew about it, but that there were few actual educators present in the room. She hoped her session would allow delegates to start to think about implementing adult education learning theories in developing CME materials.

Fawcett reviewed changes in learning techniques as brought about by the advent of the internet. Learning has traditionally been linear and focused on memorising facts and figures. The age of the internet has changed the style of learning by speeding up access to information and how it needs to be retained for practical use. It is no longer necessary to process masses of information; instead people are looking for concise pieces of information in a targeted fashion that can be repeated and therefore validated.

All information is linked, but learners now look for information from various sources; so one learning programme does not necessarily fulfil all educational needs. The modern learning process involves gaining little pieces of information from a variety of places. The skill now is not memory, but how to filter and process information, and how to learn things and then unlearn them as the need arises.

Asking the question “how is this implemented in e-learning?”, Fawcett discussed instructional design and how educational messages are to be transmitted. In terms of developing e-learning there needs to be a combination of components: an understanding of the context, as well as learning theory and methodology expertise, medical expertise and implementation expertise.

Impact of eCME on clinical practice

The next presentation provided an example of how to take different styles and put them into a blended learning package. Jörg Ansorg (Professional Board of Surgeons, Germany), compared today’s practice in CME to the future plans of the German Professional Board of Surgeons, which has been using e-learning courses since 2002. As a result, usage of e-learning is increasing but is lower than...
<table>
<thead>
<tr>
<th></th>
<th>When operating new equipment for the first time I prefer to…</th>
<th>Read the instructions or watch a video</th>
<th>0%</th>
<th>Listen to or ask someone for an explanation</th>
<th>12%</th>
<th>Have a go and learn by ‘trial and error’</th>
<th>12%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>To explain a new concept to someone I…</td>
<td>Use visual aids such as a flipchart or slides to illustrate the concept</td>
<td>3%</td>
<td>Explain the concept verbally, usually without the use of props</td>
<td>24%</td>
<td>Demonstrate how to achieve the concept in a task and let them have a go</td>
<td>18%</td>
</tr>
<tr>
<td>3</td>
<td>I tend to say…</td>
<td>“I see what you mean”</td>
<td>9%</td>
<td>“I hear what you are saying”</td>
<td>21%</td>
<td>“I know how you feel”</td>
<td>16%</td>
</tr>
<tr>
<td>4</td>
<td>I tend to say…</td>
<td>“Show me”</td>
<td>15%</td>
<td>“Tell me”</td>
<td>20%</td>
<td>“Let me try”</td>
<td>19%</td>
</tr>
<tr>
<td>5</td>
<td>When I am working through an e-learning module I…</td>
<td>Write notes and draw diagrams while working through the content</td>
<td>19%</td>
<td>Listen to video and voiceover</td>
<td>13%</td>
<td>Go straight to the assessments</td>
<td>14%</td>
</tr>
<tr>
<td>6</td>
<td>If I was offered different formats of the same material I would choose…</td>
<td>A printed version</td>
<td>18%</td>
<td>A podcast</td>
<td>5%</td>
<td>An activity sheet or workbook</td>
<td>12%</td>
</tr>
<tr>
<td>7</td>
<td>If I am learning something new in a workshop or classroom session…</td>
<td>I prefer to watch what someone is saying or showing in a presentation</td>
<td>13%</td>
<td>I prefer a question and answer session or a group discussion</td>
<td>4%</td>
<td>I prefer getting an activity to do</td>
<td>4%</td>
</tr>
<tr>
<td>8</td>
<td>When I need to memorize something I…</td>
<td>Write notes and summaries</td>
<td>11%</td>
<td>Repeat the information over and over in my head, or aloud</td>
<td>0%</td>
<td>Walk around and gesture to myself while repeating information aloud</td>
<td>4%</td>
</tr>
<tr>
<td>9</td>
<td>When having to give instructions for a task to someone I find it easier to…</td>
<td>Show them a previous example of a task and give them a written brief</td>
<td>9%</td>
<td>Chat to them and explain the task in various ways until they understand</td>
<td>1%</td>
<td>Do the task with them step-by-step</td>
<td>0%</td>
</tr>
<tr>
<td>10</td>
<td>I find it easiest to remember…</td>
<td>Faces</td>
<td>3%</td>
<td>Names</td>
<td>0%</td>
<td>Activities</td>
<td>0%</td>
</tr>
</tbody>
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Fig. 2. Achieving the LEARNING in e-learning: worksheet: results as given by delegates. Reproduced with permission from Cally Fawcett (DeltaKn, UK).
expected given the 16,000 members of the Board across Germany.

Ansorg suggested that future practice in CME would be through the use of blended learning – a combination of electronic learning and hands-on workshops in which the participant has to complete an e-learning preparation and assessment module before undertaking the hands-on practical part of the course.

Ansorg described a further development involving the inclusion of mental training. This will follow an established technique used by athletes in their progress through a particular move or action during training. The opportunity for surgeons to undertake mental training will allow them to visualise procedures within an operation before they move onto the practical course.

**Accreditation can improve the quality of e-learning**

Chair, Edwin Borman, completed this session by providing an introduction to the European Union of Medical Specialists (UEMS) and the EACCME, a basic overview of CPD and some information about the accreditation of e-learning. He then explained what the UEMS-EACCME has learned about the implementation of this form of accreditation, and hopes to share with a much wider audience.

Borman focused on a specific UEMS policy document – *The Accreditation of e-Learning Materials by the EACCME* (Document D9908, published in 2008; for details see Further reading). This document mandates the application of explicit principles and transparent procedures for the accreditation of e-learning materials, with the aim of raising standards. Borman explained that the UEMS is planning to ‘retro-fit’ these higher standards for e-learning accreditation to live programmes, hopefully, therefore, also raising the standards for the accreditation of live programmes.

Borman listed the criteria for e-learning accreditation. These include:

- fulfilment of learning objectives
- description/nature of material
- details of the provider
- quality assurance by the provider
- accreditation by EACCME
- outcome measures employed.

He explained that UEMS is implementing a new level of accountability where the details of the doctors involved in providing the learning programme are made available to the learners. This means that the doctors involved will be aware that they are potentially accountable to their registration bodies if they are distributing documentation or information that is invalid (and, in the process, personally vouching for the education).

**Learning from implementation**

- Many applications that have been rejected in the past are in fact very close to being acceptable.
- UEMS has decided to allow for a feedback stage in the review process so that there is an opportunity to make amendments or improvements and to make the programme compliant for accreditation.
- The EACCME online system needs improvement. It is currently being redesigned and will be updated as soon as possible.
- There is much innovation and constructive discussion ongoing among providers. As a result, UEMS has re-evaluated some of its processes for accreditation.

Blended learning programmes attract much attention. Borman explained that the live and e-learning modules of such programmes currently have to be reviewed for accreditation separately but, as Chair of the taskforce on EACCME, he informed delegates that this would be reviewed.

The situation regarding the UEMS considering accreditation provider status was also discussed, especially in situations in which a provider may be presenting many online modules, thus putting an inordinate strain on the UEMS-EACCME system as well as incurring greater cost. Borman explained, however, that UEMS is concerned about adopting this approach as it follows examination of the system, which has been widely adopted in the USA. While there were some good examples of US accreditation providers, there are also many very bad examples. For the moment, UEMS feels that the safest way of guaranteeing good quality, particularly where multiple languages and a multitude of different healthcare systems are involved, is to look at learning modules on an individual basis.

**CME unplugged**

The objective of this session was to consider a number of ‘hot topics’ in CME that affect the European environment. This was an open and informal session, where a number of issues were presented and then discussed by the audience and a panel made up of CME specialists from around the world.

The session started with Alfonso Negri (Rome CME/CPD Group and Federation of Scientific Medical Societies, Italy) presenting a concept that has been recently developed in the USA within a European context. Negri defined PI activities as being structured long-term processes by which a physician or group of physicians can learn about specific performance measures, retrospectively assess their performance, apply these measures prospectively over a useful interval and then re-evaluate their performance. He stated that the emphasis is on the role of the provider, and it is the responsibility of
the provider to ensure that three stages are embraced by the participating physicians so as to develop a complete, structured PI activity:

Stage A: learning from current practice – using identified performance measures

Stage B: learning from the application of PI to patient care – implementation of an intervention based on the performance measures selected in stage A

Stage C: learning from the evaluation of the PI effort – re-evaluation and reflection on performance in practice (stage B) by comparing it with the assessment in stage A.

While a large number of questions and statements were prepared for this session, the single issue that elicited the most discussion and debate, even through Twitter, was the question of how commercial organisations interact with CME. The discussion started with a question on which pharma department is considered the most appropriate as the source of finance from a supporting pharmaceutical company. The majority agreed that funding coming from a medical department is more appropriate than that from marketing or other commercial functions.

The US experience was discussed at length following recent developments involving the tightening of commercially supported CME and the announcements by various pharmaceutical companies of their intention to amend or withdraw their support for certain types of CME activities. Representatives from both US pharma and US providers present at the meeting acknowledged that CME in the USA is currently “in a mess” and urged delegates to “learn from their mistakes”. The point was made that in many other business sectors it is the employer who pays for the CPD of the employees.

Quality standards and controls in CME

The second day of the meeting started with a look at quality standards in CME, how they are set, controlled and maintained.

Robin Stevenson (European Board for Accreditation in Pneumology [EBAP]) chaired the session and began by reviewing the accreditation procedures for live events and e-learning programmes in Europe. He reported that fewer than 5% of applications for the accreditation of live events in Europe are rejected. In other words, more than 95% are accepted. Is it therefore right, he asked, to continue with a system that only rejects fewer than 5% of applications? Does it mean that all the applications are good; or does it mean that there is a flaw in the system that makes it easier to approve rather than to reject? He pointed out that it is difficult to assess an event just from looking at the programme and the list of speakers. Also, the assessment is usually made at a late stage in the event preparation when the programme has already been printed. Therefore, rejection by the accrediting body causes major turmoil for the provider and this favours the likelihood of acceptance.

A quick look at the European Specialty Accreditation Boards (ESABs) followed. ESABs were set up because when UEMS started EACCME it wanted UEMS sections to assess individual applications for accreditation. The sections were not sufficiently financed to be able to do this satisfactorily. Initially, cardiologists set up their own ESAB (European Board for Accreditation in Cardiology – EBAC), which was a joint venture between the UEMS cardiology section and the European Society for Cardiology. Subsequently, EBAP and others have followed suit and others are being discussed.

Fewer than 5% of applications for the accreditation of live events in Europe are rejected

This, of course, has within it a major conflict of interest. The main provider for each specialty is the European scientific society for that specialty and it appears that the system created has resulted in the provider financing the corresponding accreditation body, a problem yet to be resolved.

The above system is known as event accreditation. The alternative system, provider accreditation, allows for the accreditation authority to license the provider, following satisfactory scrutinisation of its recent record and a review of the types of delivery of the educational material, level of audience participation, use of multimedia, methods of reinforcement, etc. used by the provider.

It is argued that improved provider performance is more likely to be encouraged by provider accreditation than by event accreditation. Having been accredited, providers know what is expected of them and also know that future accreditation depends on their fulfilling these expectations. Furthermore, provider accreditation can be carried out by generalist reviewers who can spend time with each provider every few years, rather than by specialist doctors. Some consider that this would make the system easier and cheaper. The increasing importance of e-learning is another reason for considering provider accreditation, because event/individual programme accreditation, which requires the entire programme to be reviewed, is extremely time-consuming and expensive.

Four panellists then took the floor individually and presented their thoughts on these issues and the broader topic of quality standards in CME in general.

Bernard Maillet (UEMS-EACCME) reviewed the recent inclusion of e-learning materials for consideration by UEMS-EACCME for accreditation (which began 6 April 2009). Various quality criteria for e-learning materials were presented. Maillet mentioned, however, that an additional cost was payable for the accreditation of e-learning materials (€600 per module then €600 per
It is argued that improved provider performance is more likely to be encouraged by provider accreditation than by event accreditation.

Thomas Kleinoeder of KWHC (Germany), a content provider and facilitator of accreditation, offered a pragmatic view on quality standards in Germany. Through his role, Kleinoeder supports the different participants in CME activities while collaborating with industry, scientific societies, hospitals and other players in the field of CME activities in Germany. He gave delegates the opportunity to compare these standards with those in the USA that would be outlined in the next presentation.

In Germany, CME is mandatory, each physician needing 250 credits in each 5-year cycle. This does not present a problem for most German physicians. The majority, however, would still prefer to attend a CME-accredited event rather than a non-accredited one as CME is deemed a measure of high quality.

In Germany, there are common CME recommendations across the country, but each of its 16 states acts individually, with each local physicians’ chamber responsible for CME certification. Including guidance from the federal system based in Berlin, this means that there are 17 slightly different interpretations of the national recommendations which, in turn, means that a different number of CME points may be awarded for the same event when run in Munich, Berlin, Hamburg or Cologne.

Quality criteria in Germany are much the same as those of the UEMS-EACCME, except when it comes to reviewing materials for the mandatory media-based programmes. Kleinoeder takes the view that CME review is not the same as scientific peer review and prefers to involve reviewers from the target group as well as experts in the field to ensure an appropriate level of understanding and that it is aimed at improving patient care. In Germany, 300,000 physicians need 70 million CME points. This is a challenge not only practically and administratively, but also for keeping quality standards high. A provider accreditation structure would make life much easier for providers in Germany, but there is scepticism from the physicians’ chambers.

Kleinoeder was followed by Maureen Doyle-Scharff (Pfizer), who took the opportunity to repeat the hope that Europe, Asia and the rest of the world would indeed learn from the mistakes of the USA. Although Pfizer is not an education provider, Doyle-Scharff asserted that her position as Senior Director of its Medical Education Group, reviewing over 7000 grant applications per year, gave her a unique perspective on quality issues. Her position had made her acutely aware of the evaluations and outcomes of the educational interventions and activities that Pfizer supports and, therefore, gave her a good idea of what quality looks like from a grants perspective.

She provided an overview of the system in the USA where there are approximately 725 national accreditation providers. These organisations can, regardless of where they are based, produce education that covers the entire nation for any physician practising in any US state. In addition, there are 1400 intrastate providers that are still held to the same standards as the national providers, but that focus on physicians in the state in which they are based.

The framework for accreditation is based on three main components:

1. criteria for compliance
2. essential areas and elements
3. standards for commercial support.

Doyle-Scharff said that the expectation is that the framework will bring about consistency in quality, but in reality it is not clear whether the system actually works. Additionally, where CME was once a minute player in the system, it is now front-page news on the Wall Street Journal and New York Times. The perception of CME has gone from not having any impact on the quality of healthcare to being central to how physicians practise medicine and what that ultimately means to patient care.

The perception of CME has gone from not having any impact on the quality of healthcare to being central to how physicians practise medicine.

As a result of this, 22 new criteria have now been introduced to monitor accreditation providers. However, according to Doyle-Scharff, a provider that meets all of these 22 criteria would not necessarily produce high-quality educational programmes. Finally, and once again, she urged everyone at the meeting to learn from the mistakes of the USA, saying that CME does work and can work well but rigorous oversight is unquestionably necessary.

Archie Prentice (European Hematology Association) then presented what he saw as being some key principles in CME. He said that CME is about determining whether physicians are fit for purpose. Patients need to be reassured that physicians are able to look after their whole lifetime experience of a disease. As it is currently structured and operates within the EU, CME does not provide that reassurance. According to Prentice, it lacks intellectual rigour, sufficient levels of organisation and sufficient funding.
Measuring outcomes in CME

Wolfgang Grisold (UEMS Neurology Board and Section) chaired this session and began by garnering views from the audience about whether CME/CPD should be voluntary, compulsory or the basis for re-certification, and whether there is a place for patient organisations to influence doctors’ education. A significant majority thought that CME should be the basis for re-certification and that patients’ organisations should be able to influence doctors’ education. This provided the basis for a session that looked at the techniques and concepts that could be employed to demonstrate and measure uptake of knowledge.

Outcome-based evaluation

The objective of this presentation was to reflect on the evaluation experiences and challenges of the audience, and to introduce a monitoring and evaluation framework that could be applied to CME. Abi Sriharan (University of Toronto) described evaluation types in CME as:

- accreditation (process evaluation)
- before: needs assessment (formative evaluation)
- after: performance measures (outcome evaluation)

Sriharan said that many factors influence CME results and so a simple roadmap is required to guide evaluation.

Sriharan talked through the key stages that affect success using the CME Logic Framework (Figure 3). Planning starts at the results stage. Sriharan described how to define expected results first and activities later, by fostering the active participation of all stakeholders and ensuring that all stakeholders work towards achieving expected results.

Sriharan then presented a scenario that she had first introduced during the needs assessment session the previous day. She highlighted the link between how needs are assessed and the measuring of outcomes, and discussed it within the context of the CME Logic Framework using the scenario described below.

In the mock case study, an annual GPs’ survey carried out by the Canada College of Family Physicians showed that, in County A, GPs were seeing an increase in patient visits related to depressive disorders. The health department in County A was already investing new resources to implement community programmes to address depressive disorders. The audience was asked to reflect on the challenges listed below:

1. As a CME professional, what would you do with the data from this report?
2. What can you contribute to this scenario as a CME professional?
3. If a CME intervention is provided, what outcomes should be evaluated and how?

Needs were assessed by considering the target audience, what they did in their current roles as healthcare providers...
and what gaps existed between what these providers knew how to do and what they needed to know to carry out their roles successfully.

Developing the programme framework consisted of matching inputs to activities and then to results. An evaluation matrix was then considered to include questions on each element, which were then qualified through timing and data collection.

The take-home messages from the CME Logic Framework were that it:

- focused on tangible results: output, outcomes, impact
- helped clarify needs, goals and programme plans
- assisted in clarifying expected results and resources to support these
- promoted benchmarking bad performance analysis
- emphasised value for money.

Conclusions drawn were that:

- outputs are generally under the direct control of the CME providers
- outcomes that are not under complete control:
  - are subject to numerous other influences
  - only surface over time.

Hence, attribution becomes an issue:

- evaluation needs to be context specific
- multiple models may be needed to describe and explain complex initiatives or systems.

**Is there a place for patient associations to influence doctors’ education?**

Basic and continuous medical education is traditionally oriented to acquire and update scientific knowledge and skills to recognise and treat medical conditions. Conversely, training in other important skills remains in its infancy. These skills include:

- how to announce a difficult diagnosis
- how to communicate information about a disease in a way that can be understood by the patient
- how to accompany a patient on his/her difficult journey with a chronic progressive disease.

Alexandre Bis dorff (UEMS European Board of Neurology) presented results from a survey carried out by the Parkinson Association Luxembourg. The study showed that over 50% of patients found information given at the moment of diagnosis to be non-existent, insufficient or
difficult to understand; only 15% of patients were directed to information sources; and 53% of doctors’ attitudes were thought to be cold or discouraging when announcing the diagnosis.

Over 50% of patients found information given at the moment of diagnosis to be non-existent, insufficient or difficult to understand

Bisdorff said that this is not necessarily due to ill will. He pointed out that patients are experts in living with their disease every day and night, whereas medical professionals are experts in the disease.

These findings led to the launch of a ‘Guide to good practice for cooperation between doctors and patient associations for chronic neurological disorders in Europe’ at the European Federation of Neurological Societies Congress in Madrid in August 2008. The main principles covered in this publication include those of mutual respect, mutual independence and a commitment to partnership. The handling of conflicts of interest was also discussed. Aims included improving patient–doctor communications, and education and research.

Comments from the floor endorsed this approach but also recommended a national benchmarking system in patient feedback whereby performance can be measured against all the GPs in the country. This would encourage participants to improve themselves in a given area because they would not like being below the national average.

A further comment broadened the context of this discussion when it explored another aspect of the complex doctor–patient relationship that is not easy to measure. At a recent meeting of the Medical Humanities Forum it was suggested that the expert patient might inhibit the professionalism of the doctor. Certain patients can stop doctors in their tracks with questions that doctors may find difficult to handle, and this can prevent doctors from pursuing what is wrong with those patients.

Bisdorff said that this is not just about making the patient feel comfortable. He concluded that it is too complex an area for simple questionnaires and requires more detailed insights.

Revalidation in the UK is defined as a set of procedures to secure the evaluation of a medical practitioner’s fitness to practise

Trust, assurance and safety

Revalidation has two components: relicensure and specialist recertification (Figure 4). This is a single process that includes a revised and strengthened appraisal and assessment process.

Revalidation = Relicensing + Recertification

Relicensing demonstrates that the doctor practises in accordance with the GMC’s generic standards

Recertification confirms that he/she continues to meet the standards that apply to his/her discipline, as managed by the Royal Colleges

Fig. 4. Revalidation in the UK.

Starke outlined the three aims of revalidation:

1. To confirm that doctors practise in accordance with the GMC’s generic standards.
2. For doctors on the GP register and specialist register to confirm that they meet the standards appropriate to their specialty or general practice.
3. To identify for further investigation and remediation poor practice where local practice is not robust enough to do this or does not exist.

Assuring the quality of medical appraisal for revalidation

In the UK, responsibility for fulfilling CPD lies with the learner – in this case the doctor. Most educationalists recognise that this has been the case for some time. The employer should provide support for this process in partnership with other relevant bodies and should have a CPD strategy in place.

The employing organisation should have a written description of the relationship between CPD (CME) and the pharmaceutical industry. Monitoring and reporting processes should be in place to provide assurances
about the effectiveness of the CPD system that the employer has in place.

In response to this, the Academy of Medical Royal Colleges has developed a template for CPD guidelines and is beginning to harmonise criteria across all of its colleges.

Starke described what is generally acceptable and what is definitely not acceptable in terms of payments, gifts, logos, sponsorship, etc. He was especially scathing of providers that use CPD approval as a form of inducement for people to attend.

The UK pharmaceutical industry and CME/CPD

The Association of the British Pharmaceutical Industry (ABPI) is focused on the VITA agenda (Table 1), which comprises the four imperatives of: Value, Innovation, Trust and Access.

<table>
<thead>
<tr>
<th>VALUE</th>
<th>of medicines to the UK economy and in terms of outcomes for patients</th>
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<tbody>
<tr>
<td>INNOVATION</td>
<td>in terms of creating the environment in the UK that creates innovation</td>
</tr>
<tr>
<td>TRUST</td>
<td>– about being a trusted partner in the healthcare system</td>
</tr>
<tr>
<td>ACCESS</td>
<td>to medicines for people in the UK</td>
</tr>
</tbody>
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Table 1. The VITA agenda. Reproduced with permission from Andrew Powrie-Smith (ABPI).

As leader of the ABPI’s Trust Imperative, Andrew Powrie-Smith (ABPI) presented the issues that he is currently tackling in his role:

• Behaviours are coming under scrutiny in terms of influencing of inappropriate prescribing. Whether actual or perceived, the ABPI needs to tackle these behaviours.

• Openness and transparency differ greatly between companies. There is a huge variance in the UK industry regarding the level of transparency across different companies.

• In terms of communication, the industry is not very proactive, but is very reactive when it comes to regulatory and other issues.

As an industry, pharma has viewed itself as having a traditionally narrow model of engagement that has focused on the prescriber for many years but, as the environment changes, if pharma wants to develop trust across society, it needs to broaden its engagement.

Consultation has resulted in a number of actions that are to be examined further. These include:

• the adoption of a co-funding model for supporting education, training and meetings

• ceasing the provision of promotional aids

• separating the provision of promotional aids from the role of the representative

• transparency in payments made to healthcare professionals and healthcare organisations

• transparency in research

• increased transparency in payments made to patient organisations

• transparency in payments made in the public domain.

Since this was the first outing for this information, Powrie-Smith asked for audience response to the issues raised. Many present were concerned with pharma funding of various initiatives. The majority were in favour of a co-funding model of some kind for CME, whether based on a 50/50 fixed bursary or another percentage shared funding model. For international congresses, a large majority were in favour of changing the way pharma supports attendance. Various models were proposed, with no clear favourite, although 16% supported no funding at all. However, there was a majority in favour of no change to the way in which pharma supports non-accredited medical education, training and meetings.

Finally, complete transparency was embraced by over 70% of delegates who thought that payments for such things as education, training, consultancy fees, speaker fees and advisory boards should be in the public domain.

Accreditation developments in Europe

Bernard Maillet returned to the podium with a European overview. He compared a complete ban on pharmaceutical company support of CME with no control at all, and national regulations with those associated with large regions such as Europe and Asia, and international guidelines from the Rome Group.

Maillet’s conclusions were without compromise. CME without industry support is impossible. An industry ban is not the solution but clear rules are much more effective.

CME without industry support is impossible

Thomas Kellner (MSD) was the final member of this panel to address the topic of pharma/learner relationships and talked about changing the perceived role of industry into a rather broader perspective than just simply that of a commercial organisation.
He described how, when it came to CME, the meeting had addressed improving outcomes, quality, the demand for reducing dependency on commercial sponsors, provider versus event accreditation, and the demands for more transparency and declaring conflicts of interest; but there was still one unanswered question – what is the appropriate role of industry?

It had been acknowledged during the meeting that industry might play an essential role in supporting education, but how did it fit in? He drew the analogy that if a cake was bad for your health because it had too much sugar, would the solution be to remove the cake or to remove the sugar? Some would want to remove the cake, but this would have wider and long-term consequences. Similarly, should the pharma industry be viewed only as a sales department, or is the sales department just one piece of the industry?

Sales and marketing are a significant part of the industry but most focus is on research. The industry should not be reduced to a just a selling organisation. If the pharmaceutical industry is to survive, it needs to listen and forge good relationships with its customers. Pharma will have to change its business model.

If the pharmaceutical industry is to survive, it needs to listen and forge good relationships with its customers

What will be the future business model of industry? Will it be a product-driven or a customer-driven business model?

Where some strategies have already changed (e.g. the removal of promotional items) this might be expected to have a significant impact on pharma business, but it has been shown to have had no effect. That is not to say that giving away promotional items is the right behaviour for a pharmaceutical company. Kellner said that pharma needed to focus on what is an appropriate role, and giving away promotional items is not an appropriate part of that role.

The challenge for the future is to develop a business model that will retain relationships with all stakeholders. As the old blockbuster industry model is disappearing, so the old way of promoting medicines to a few stakeholders will also die.

Kellner concluded by saying that there are many appropriate ways of providing education. If the role of industry, however, is reduced solely to one of sponsorship, this would reduce quality. Instead, pharma should adopt the more professional stance of educator. Within pharmaceutical organisations, responsibility for education should be moved to an appropriate level – i.e. away from sales and marketing. If the pharmaceutical industry wants to reduce inappropriate influence, it will also need to adopt the concepts discussed at this meeting, so as to identify poor quality and inappropriate results.

The CME unsession

The last session of the meeting was led by Lawrence Sherman (Prova Education) and was designed to complement his first session at the start of the meeting, and to address any issues overlooked by the speakers or panellists during the course of the two days.

Sherman kept the delegate feedback flowing, with many questions and points being raised, noted and addressed. There was much interest in online activities and discussion as to how current systems can be more flexible and also in the use of case studies and techniques to better engage learners so that they gain more value from the education. Likewise, discussion looked at how new technology such as Twitter and LinkedIn could support the needs assessment process, and could be used as invitation and dissemination tools.

Finally, Sherman asked questions of the audience to determine, amongst other things, whether delegates felt positive about the potential for CME in Europe. The response was 76% in favour, which encouraged those in the room – including those who had initially thought otherwise.

Meeting close

In closing the meeting, Eugene Pozniak outlined plans for the future activities of the European CME Forum, such as the launch of the European Journal of CME in 2010. The third annual meeting will take place in Berlin on 17–18 November 2010.

Conclusion

The European CME Forum 2009 developed the ideas presented at the 2008 meeting. The more hands-on approach, with a more relaxed scheduling and the interactivity offered by ARS, allowed for a lot of free-flowing discussion and much time for questions and discussion. While some delegates – possibly those preferring a more didactic learning environment – found this off-putting, the overwhelming majority reported in the meeting feedback that they valued the more interactive approach for a meeting of this type.

While some discussion of European CME in recent years has focused on the shortfalls of systems or on the way things are enacted and even abused, what flourished during this meeting was that all parties were prepared to air their own concerns, and to listen and learn from each other.

An overarching theme that emerged was that of reflection and self-examination. There was a willingness to share ideas and work through potential scenarios, from reaching an agreement on the best way to approach common activities, such as the process for assessing learner needs or evaluating educational outcomes, or on how CME can
benefit from the involvement of patients or patient groups, to the more speciality-specific challenges, such as:

- how CME accreditation bodies review and accredit educational programmes
- how pharmaceutical companies can engage with CME in a less commercial and more credible way
- whether the education provider community is willing to participate as educators (rather than just agents of clients)
- how to define standards that can be worked to in a credible and demonstrably competent way.

There are many common goals emerging. Now there are clearer paths to follow to devise common guidelines that each party can work to, productively and to best serve the learner.

Further reading/online resources

Further information can be found at the European CME Forum website: www.europeanCMEforum.eu

Documents

European Union of Medical Specialists (UEMS) Document D9908. Available at www.uems.net/uploadedfiles/47.pdf


RCGP Guide to the Credit-Based System for CPD. Available at www.rcgp.org.uk/PDF/Credit-Based%20System%20for%20CPD_final%20version_201009.pdf

Educational courses

Master of CME Management Skills (MCMEMS) www.mcmems.org

University of Toronto: Continuing Education Leadership Program (CELP) www.cepd.utoronto.ca/?page_id=206

Websites of ESABs and related medical organisations

Academy of Medical Royal Colleges www.aomrc.org.uk

Accreditation Council of Oncology in Europe (ACOE) www.acoe.be

Association of the British Pharmaceutical Industry (ABPI) www.abpi.org.uk

European Accreditation Council for CME (EACCME) www.eaccme.eu

European Association of NeuroOncology (EANO) www.eano.eu

European Board for Accreditation in Pneumology (EBAP) www.ebap.org

European Board of Accreditation in Cardiology (EBAC) www.ebac-cme.org

European Federation of Pharmaceutical Industries and Associations (EFPIA) www.efpia.org

European Hematology Association CME (EHA CME) http://cme.ehaweb.org

European Union of Medical Specialists (UEMS) www.uems.net

General Medical Council (GMC) www.gmc-uk.org

Royal College of Physicians (RCP) www.rcplondon.ac.uk

The Good CME Practice Group

The aim of the Good CME Practice Group is to look specifically at how the European education provider/agency community works in CME and to develop the appropriate operating standards

For more information see: www.gCMEp.eu
Good CME Practice Group Inaugural Meeting

Immediately following the final formal session of the European CME Forum, delegates were invited to stay on for the inaugural meeting of the Good CME Practice (gCMEp) Group. There was a broad spectrum of representation from the provider/agency community, including – from the USA, as well as some representation from CME accreditation bodies and pharmaceutical companies.

Eugene Pozniak opened the meeting by discussing the need for clarity in communication. No rules or standards currently exist for education providers when working on European CME programmes, and the onus is on CME professionals to come up with their own guidance. Pozniak described how the gCMEp Group would be underwritten by the European CME Forum, and already had the backing of a number of organisations, including the World Forum for CPD and the two provider sponsors of the main meeting – International Medical Press and The Oxford Academy for Professional Health Education.

Alfonso Negri (Italian Federation of Scientific Medical Societies) presented a summary of the critical factors to be considered when education providers engage with CME from the perspective of a CME accreditation body and healthcare professionals. He revealed plans to present this initiative to the Rome CME/CPD Group, which has been working towards the harmonisation and globalisation of principles. He offered support for the initiative, citing mutual objectives and collaborative benefits.

Thomas Kellner (MSD), who presented a perspective from the pharmaceutical company supporter angle, agreed with many things defined by Negri and the work of the Rome Group, as well as the initial objectives of the gCMEp Group. He had, however, specific concerns with some terminology such as ‘bias’ and ‘commercial sponsor’. Kellner said that the roles and contributions of various partners needed to be clearly defined and that the process of developing CME should be designed around objectives and outcomes rather than what should be avoided.

Defining Good CME Practice

On behalf of the gCMEp Group, Sheila Farrow (International Medical Press) presented the six draft core principles for discussion and invited comments from the floor. The principles were put forward as initial suggestions that could be adopted by education providers in order to demonstrate a high level of professionalism by working via transparent relationships and to appropriate standards. The six core principles presented for discussion were:

1. Needs-based education – proper needs analysis with a primary aim to improve clinical practice
2. Quality – develop using evidence-based medicine with robust data and rigorous review processes
3. Independence – agency, supporters and faculty
4. Fair balance – evidence-based medicine, best clinical practice, peer review, complete disclosure and all data shown
5. Transparency (possibly the most essential component) – acknowledge sponsor support and define its role, pertinent disclosures from faculty, clear statement explaining how and by whom the education was developed
6. Effectiveness – measurement of knowledge gain against learning objectives, review and analysis of feedback, demonstration that the learning was meaningful.

Notable discussion points included the use of separate agency teams to deliver CME and promotional programmes. Queries were raised regarding the delivery of integrated programmes that include both elements. Many realities have to be addressed and wording will be worked through to define agreeable working practices.

Another discussion point was the goal of achieving fair balance. Independence will never be proven as long as exchange of funds (sponsorship) takes place. Transparency allows openness, and it is possible that the principle of independence could be combined with that of transparency. The six core principles may therefore turn into five.

In terms of funding, Pozniak broadly outlined the structure for a suggested membership fee of €1500 per year (per education provider/agency). This would incorporate a number of feature benefits, including:

- an annual benchmarking report
- European CME Forum discounts, such as discounted places at the gCMEp Spring Meeting (to take place in London in May)
- preferential rates to those completing the Master of CME Management Skills (MCMEMS) on-line course
- access to the proposed European Journal of CME.

It was put to the attendees that, if enough interest and support becomes evident, the initiative would be taken forward, with a Working Group to produce a discussion document for further refinement. Following additional declarations of support after the meeting it was agreed to proceed and launch this initiative in February 2010, with a period of consultation to review and develop the core principles.

For more information, visit the gCMEp website at: www.gCMEp.eu
Executive Summary

The European landscape for continuing medical education (CME) is diverse and complex. The absence of a common framework across the region has led to individual countries developing their own national objectives and building a range of systems, each at differing stages of advancement. While similarities in approach exist, the key European markets demonstrate notable differences in both style and in how CME is being implemented. Nevertheless, a widespread appetite for collaboration and sharing best practice is driving European CME forward.

Despite such a fragmented and disparate environment, efforts to develop a recognised system for CME accreditation across Europe and to establish a harmonisation of credits and practices are progressing. Definitions of CME remain subjective and discussions continue as to whether it should just address levels of knowledge and competence, or go further and have a positive effect on clinical performance. Determining which activities actually constitute CME is similarly challenging: activities such as e-learning promise to provide the engine for CME in the future, whereas the accreditation of satellite symposia remains contentious. Meanwhile, traditional activities such as conferences and workshops continue to dominate.

In such an evolving climate, two central issues for CME development in Europe resonate loudly: the quality of programmes and the impact they have on clinical practice. Stakeholders remain determined to ensure that education is not only free from commercial bias but that it also promotes participation that leads to better clinical outcomes.

This Conference Insights report provides an in-depth review of the first annual meeting of the European CME Forum held in London, UK on 4–5 November 2008. It examines the development of CME activity across Europe, providing perspectives from the full range of stakeholders: healthcare professionals, medical societies, pharmaceutical companies, medical communications agencies and CME accreditation bodies. It explores the need to set quality standards in European CME, and to achieve harmonisation across the region. It shares implementation strategies and assesses how best to measure their success. It also looks at the critical aspect of funding, providing a basis for guidelines on how to manage conflicts of interest, avoid commercial bias and, crucially, raise standards. Clearly, maintaining a balanced relationship between healthcare professionals, CME organisations and the pharmaceutical industry remains pivotal to the future of CME.

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About the author

Eugene Pozniak is Programme Director of the European CME Forum and also Managing Director of Siyemi Learning, an independent European CME provider. He has worked in the medical sector for 20 years. Following a degree in chemistry, he initially worked across various functions in marketing and medical communications. Since 2000, he has been working exclusively in CME.

As well as managing CME-accredited meetings, Eugene developed the first pan-European CME-accredited e-learning (launched in 2002), national CME-accredited portals and has been working on European journal CME. In addition, he has developed a number of bespoke CME and ‘non-CME-non-promotional’ projects. Eugene has experience of CME across Europe, the USA, Asia Pacific and Latin America.

In 2006, Eugene founded Siyemi Learning, an independent provider of CME programmes and related services; he also supports the European CME-CPD Academy, an independent platform for accredited e-learning in Europe.
Drug reviews:

Etravirine (TMC-125): the evidence for its place in the treatment of HIV-1 infection
ThePharmYard product code: core052

Exforge® (amlodipine/valsartan combination) in hypertension: the evidence of its therapeutic impact
ThePharmYard product code: core051

Agomelatine: the evidence for its place in the treatment of depression
ThePharmYard product code: core050

Eptifibatide: the evidence for its role in the management of acute coronary syndromes
ThePharmYard product code: core049

Temozolomide: the evidence for its therapeutic efficacy in malignant astrocytomas
ThePharmYard product code: core048

Omalizumab: the evidence for its place in the treatment of allergic asthma
ThePharmYard product code: core047

Tolvaptan: the evidence for its therapeutic value in acute heart failure syndrome
ThePharmYard product code: core046

Prucalopride: the evidence for its use in the treatment of chronic constipation
ThePharmYard product code: core045

Ivabradine: the evidence of its therapeutic impact in angina
ThePharmYard product code: core044

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