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A KeywordPharma Conference Insights review by Eugene Pozniak and David Williams

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3rd Annual Meeting of the European CME Forum

in-depth report of a meeting held in Berlin, Germany, 16–17 November 2010

by Eugene Pozniak and David Williams

Executive Summary

The 3rd Annual Meeting of the European CME Forum (ECF) took place in Berlin, Germany, in November 2010, following two successful meetings in London. The ECF brings together the stakeholders of European continuing medical education (CME) to discuss key issues affecting the development and practical application of CME in Europe.

The 2010 meeting showed that discussion had progressed from merely talking about systems and points towards more practical elements of delivering high-quality programmes that fulfil both the educational and CME needs of the learner. For the first time, discussions also focused on the needs of patients.

Presentations highlighted an increased desire for providers of education to move away from being mere facilitators of programmes towards assuming the role of educators. Providers showed an intent to shoulder the responsibilities of driving needs assessment, devising programmes and evaluating the outcomes of educational activities.

Interactive sessions saw delegates reveal their frustrations with the European state of play, with poor direction from regulatory bodies possibly stifling the development of pharma-supported CME in Europe. Evidence suggests that fewer CME programmes are being funded from within Europe, with funding being moved to the USA. Although discussions acknowledged that much can be learnt from US experience, the sense of a loss of direction in Europe pervaded.

Moves to consolidate the position of various stakeholders, such as the work of the International Pharmaceutical Alliance for CME and the Good CME Practice Group, will help to solidify expectations in Europe and help clear a path to a more cohesive approach to CME.
3rd Annual Meeting of the European CME Forum

in-depth report of a meeting held in Berlin, Germany, 16–17 November 2010

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: Putting the patient first

Chair: Ian Starke (Director of CPD, Royal Colleges of Physicians)

The mobilisation of patients in Europe
Alex Wyke (CEO, PatientView)

Patient information – and how patient advocacy strengthens education and best practice
Jan Geissler (Co-Founder, CML Advocates Network)

Day two

Session 4: Question time

Chair: Robin Stevenson (Immediate Past President, European Board for Accreditation in Pneumology)

Panellists: Jan de Monchy (Chairman, UEMS Section and Board Allergology and Clinical Immunology), Carry Pesch (Senior Operations Director, primE Oncology), Jonas Nordquist (Director, Medical Cases Centre, Karolinska Institute), Maureen Doyle-Scharff (Senior Director, External Medical Communications, Pfizer)

Session 5: New developments and relationships in CME

Chair: Alfonso Negri (Technical-Scientific Secretary, Italian Federation of Scientific Medical Societies and Chair, Rome CME-CPD Group)

Spanish CME is growing. Are we on the correct direction?
Arcadi Gual (Coordinator, Professional Area of the Spanish Medical Council – CGCOM. General Secretary of Spanish Accreditation Council for CME – SACCME)

New developments and relationships in CME
Bernard Maillet (Secretary General, UEMS-EACCME)

Needs and outcome assessments as opportunities to establish relationships between the CME provider and the healthcare professional
Philipp Leuschner (Medical Scientific Liaison Manager, EIMSED)

Value to public health and business value to commercial supporters: can there be an appropriate match?
Thomas Kellner (Global Leader Medical Education, MSD)

Session 6: Learning about learning

Jonas Nordquist (Director, Medical Cases Centre, Karolinska Institute)

Session 7: The CME unsession

Lawrence Sherman (SVP Educational Strategy, Prova Education)

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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.

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**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.

Following his degree in Chemistry, Eugene spent 12 years working in a variety of positions in the pharmaceutical industry, advertising and medical communications agencies.

He left the promotional sector for good in 2000, working since then exclusively in Continuing Medical Education (CME).

Eugene gives advice on CME matters and develops CME accredited programmes, both live events and e-learning, primarily for European doctors (pan-European and National). He also has experience in CME for North America, Latin America, South East Asia, Japan and the Middle East.

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 which in addition to running its annual meeting also supports the Good CME Practice Group and during 2011 will be launching a scholarly journal in CME.

Eugene can be contacted at: epozniak@siyemi.org

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, David worked with a broad range of agencies primarily in business development roles. With a focus on publication planning and brand development, he 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 in Europe, America and Asia 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; is a member of the European CME Forum and a founding participant in the Good CME Practice Group.

Since becoming a consultant to the industry, David has been engaged in reviewing the medical communications sector across the whole of Europe. He is currently occupied developing models for the assessment of effectiveness of medical education as part of medical Continuing Professional Development, and its impact on day-to-day medical practice.

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3rd Annual Meeting of the European CME Forum
in-depth report of a meeting held in Berlin, Germany, 16–17 November 2010

Introduction

The 3rd Annual Meeting of the European CME Forum (ECF) was opened by Eugene Pozniak (Programme Director), who provided a brief history of the ECF. He explained that the ECF came about because of the need for the primary stakeholders in European continuing medical education (CME)/continuing professional development (CPD) to get together and talk about the issues affecting CME in general; the annual meeting acts as a benchmarking exercise conducted freestyle. The ECF aims to encourage discussion and debate, not on the theory of CME, but on the practicalities of how to implement it in the modern environment.

Pozniak outlined how the business environment has changed over the past year. Questions have been raised regarding the use of social media, and new regulations surrounding publications and conflicts of interest are accompanied by increasing levels of scrutiny and the need for unparalleled transparency. While grappling with these issues, pharma is also expected to embrace CME but faces an almost insurmountable challenge in terms of understanding CME in Europe. This point was vividly illustrated when Pozniak displayed a blank screen to illustrate the total guidance available for European pharma companies from the regulatory bodies on how to interact with CME in Europe. What is pharma supposed to do when it comes to European CME?

In the absence of any guidance from groups such as the European Federation of Pharmaceutical Industries and Associations (EFPIA), the Association of the British Pharmaceutical Industry (ABPI) or their international equivalents, pharma has formed its own global group to discuss the issues that affect it in relation to CME. Similarly, the Good CME Practice Group (gCMEp, a group of CME providers in Europe) has come together to forge and ratify core principles of best practice within its sector. But, said Pozniak, it is important for all of the stakeholder groups to talk, not only among themselves but also to each other at events such as the ECF.

As far as providers are concerned, the development and delivery of CME in Europe is mostly carried out by medical communications (MedComms) agencies or their sister companies, but the communications sector itself is diverse. Pozniak presented a slide displaying the breadth of activities from ‘pure education’ (CME/CPD) to ‘pure promotion’ (advertising) to show where the overlap lies between different types of agency (Figure 1). Whereas advertising, public relations (PR) and MedComms agencies are relatively well defined, in Europe the specialist CME/CPD provider is only just starting to emerge.

In the USA, the structure is highly regulated. For example, it is forbidden for an advertising agency to do CME. In Europe, however, these systems are not in place. It depends upon the CME accreditation body as to which commercial organisations can engage in CME.

Assessing our own educational needs

Lawrence Sherman (SVP Educational Strategy, Prova Education) kicked off proceedings by emphasising the need for all present to contribute in order to create positive outcomes from the meeting. During the closing ‘unsession’ last year, Sherman had identified the future needs of those present. These included questions about methodologies that engage and educate, and the role of new technologies in CME. Overall, there was a general positive feeling towards European CME. Yet very little appears to have moved forward in the intervening 12 months.

Questions were put to the audience to try to establish why. One response suggested that while it was great having the discussion in the room, what is still needed is discussion between individuals within the stakeholder groups themselves, especially the education providers and the pharma supporters. Some of that had happened over the year and so the meeting could address relevant issues in more depth as a result of this preparatory work.

One participant identified a gap in this year’s (and last year’s) meeting – the absence of national and European scientific societies. These agencies are major CME providers, but seem unwilling to engage in a meeting such as the ECF. In response, it was acknowledged that although some societies are represented not all are represented commensurately with their level of participation within CME in Europe.

Concern was aired over how pharma understands CME and perceives its role within it in Europe. Whilst it was acknowledged that some companies fully comprehend and embrace CME, they are the exception rather than the rule. Mostly CME is tagged on as part of an overall strategy that is funded from marketing budgets. As these...
broad budgets become restricted, CME suffers because it is not understood and is regarded as less of a priority.

Delegate response from pharma was that even in enlightened companies that do understand CME and separate it from marketing, the challenge is that while they have the money and want to do it the right way, they discover that there is no guidance.

Another delegate commented that he would like to hear a real dialogue between the three different stakeholders – accreditation bodies, pharma and providers. It is essential that there is a mutual understanding between these parties before governments start making decisions for them. It was acknowledged that the ECF meeting presents a great opportunity for these three stakeholders to unite around a consensus for CME/CPD in Europe.

The ECF meeting presents a great opportunity for stakeholders to unite around a consensus for CME/CPD in Europe

Session 1: Putting the patient first

Ian Starke (Director of CPD, Royal Colleges of Physicians), as session Chair, introduced the topic of lay involvement in the education of healthcare professionals. Starke emphasised that it is not just patients who should be considered, and proposed three questions for delegates:

1. How should patients, carers and the public be involved in the development and delivery of CME/CPD?
2. What expertise is required of those who are contributing to this?
3. What evidence is there that lay involvement is effective?

Lay involvement in the UK

CME/CPD is often regarded as a process that includes:
- needs assessment
- policy and systems
- development and delivery
- quality assurance
- feedback.

Lay involvement could play a role in all of these factors. In the UK, such involvement is delivered through policy committees which, in turn, report to the individual colleges and faculties of the Academy of Medical Royal Colleges.

Needs assessment

Starke described how needs assessment for individual doctors is carried out during the revalidation process.

![Diagram of communications agencies](image)
that, amongst other things, looks at the behaviour of doctors and how doctors interact with patients. A system of feedback is developing that involves three steps:

1. Patient and carer questionnaires
2. Involvement in the decision-making process about individual doctors made in their workplace
3. Involvement in the decision-making process in relation to doctors who may be failing – made by the General Medical Council (GMC).

In its recent review, the GMC favoured patient and carer questionnaires to inform personal CPD plans. The Royal College of Nursing also endorses this approach.

However, the Picker Institute Europe (a not-for-profit organisation that builds and uses evidence to champion the best possible patient-centred care), disagrees, saying: “Picker Institute Europe emphatically disagrees with the GMC’s stated position that patient and public involvement in revalidation is one way of inspiring confidence in the way that revalidation will work”.1

This immediately raises questions as to the benefit of patient and carer questionnaires. Do patient questionnaires provide real impetus to doctors to improve their behaviour?

Policy and systems
Policy and systems are in place in all medical colleges, and most medical colleges in the UK have a lay advisory group made up of volunteers. Some of these volunteers may have been patients, and all are non-clinically qualified but have a range of expertise that they would like to bring to bear.

Is this a valid way of engaging with the lay public, or is it an example of tokenism?

Development and delivery
The concepts of development and delivery are clear but are split into three distinct operations – activities run by lay organisations, activities including lay input and activities promoting lay perspective.

Quality assurance
In terms of quality assurance, the patient questionnaire should be repeated and fed back to measure whether an activity has changed an individual doctor’s practice. Determining whether a national or regional activity has changed a doctor’s practice is much more difficult and expensive to measure, but it can be achieved using targeted questionnaires.

Feedback
Lay feedback for the individual doctor is once again delivered via the patient questionnaire. Assessment of the educational quality of an activity requires lay members to attend the activity or evaluate change. This is not something that is done very often but could be considered more frequently. Finally, one suggestion that raises some interesting questions is open access to records of doctors’ CME/CPD activity. So far the idea that the CME/CPD activities of doctors should be open to public scrutiny has been rejected on the basis that public access to the private areas of the Royal Colleges’ websites could compromise confidentiality.

The mobilisation of patients in Europe
Alex Wyke (CEO, PatientView) discussed how the classic support groups that have existed for decades have evolved to become representative of the patient voice in volume. The problem is that no-one has recognised or given credence to what these groups have been saying. But this is changing, primarily through lobbying and the rise of the civic movement across Europe.

The focus on doctor–patient communication has been primarily in the consulting room – the one-to-one relationships between the patient and the doctor. Wyke discussed a survey conducted by PatientView in the UK that showed that this relationship is becoming less patriarchal, but there is still a long way to go before it becomes a truly collaborative partnership. Patients are, however, influencing change at the higher, policy-making level.

Wyke addressed five main areas before drawing some conclusions from a further PatientView study entitled “What do patients want from their doctors?” (published in February 2011).

1. How the world of doctors is changing
The once secure and predictable world of pharma is changing. Historically, R&D produced new products that were marketed to doctors who, in turn, prescribed them, generating money for pharma companies to re-invest in R&D. The patient did not feature in the old world, except as a willing recipient who took, without question, the medicine and care that were prescribed. This has fundamentally changed. Patients are now aware of the pressures doctors are under to behave according to guidelines, rather than according to the individual needs of the patient.

2. The growth, size and shape of the patient movement
The scale of the patient movement is vast and growing. In Europe alone there are more than 63,000 patient groups (>100,000 worldwide) that PatientView is aware of. The fastest increase is being seen at a community level, where membership numbers can be low. The average membership is in the region of 250, but some groups have over 1 million members worldwide. Networks are forming but the challenge is to get these networks operating efficiently and effectively. At the moment, they do not.

3. Patient group relationships with doctors and healthcare systems
Patient groups across the globe were surveyed about their level of contact with GPs and specialists. The survey showed that the patient groups are developing close contacts, particularly with specialists. In Germany, especially, there is a very close association between specialists and most patient groups.
4. Why patient groups are increasingly influential: internationally, nationally and locally

Patient groups are increasingly influential, and cut across what many see as the traditional disease-specific support groups. There are now groups representing older people, carers, gender-based issues, disability issues, work-related issues, etc. – all lobbying at the European level.

5. What do patients want in order to improve doctor–patient communication?

The public want doctors to see the patient as a person, rather than a medical problem (Figure 2). This, said Wyke, presents a patient-driven opportunity for CME.

**Strengthening education through patient information and patient advocacy**

In terms of CME, the International Chronic Myeloid Leukaemia Foundation (iCMLF, cml-foundation.org) is launching an education programme for doctors in emerging countries because such doctors generally cannot afford to attend big medical conferences. This example was presented as a way in which patient advocacy can work by Jan Geissler, a patient on the scientific advisory committee of the iCMLF and cofounder of the CML Advocates Network (cmladvocates.net) – a platform for 51 leukaemia patient groups in 43 countries.

Geissler presented a personal history of his experiences as a cancer patient, saying that tough decisions have to be made quickly. Access to information is crucial so that patients (or their families) can make informed decisions about understanding the disease, finding the right doctor, finding other patients and deciding on therapy. Improved information can improve outcomes.

For this and many other reasons, the role of patient advocacy groups has evolved dramatically to support and inform patients, to provide better access to treatment and to collaborate with clinicians and industry.

Geissler stressed that even in the age of the Internet as an increasingly important source of information for the patient, the doctor remains the patient’s primary partner in healthcare. However, healthcare systems do not incentivise detailed consultation and so one role of patient groups is to support the patient in needing to understand what is heard and in prioritising questions for the doctor.

Geissler showed how patient communities may be educational platforms for health professionals. For example, leukaemie-online.de is the most frequented German leukaemia patient community on the web. It provides news from research and scientific conferences, translated into German, and is regularly followed by doctors and nurses.

Geissler concluded that patient groups can support and complement doctor and nurse education. Patient involvement will strengthen, not weaken, the education of professionals.

**Patient involvement will strengthen, not weaken, the education of professionals.**

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**Session 2: Setting standards in CME**

Edwin Borman (Chair, UEMS/EACCME CME Taskforce) chaired this session and opened by putting a series of questions on regulation to the audience. A majority (83%) thought that the market in CME/CPD should be regulated, with 65% favouring the accreditation bodies as their first-choice regulator and 37% choosing industry self-regulation as their second choice. Two-thirds (67%) chose

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**Figure 2. Which improvement in the communication and understanding skills of health professionals would be of greatest benefit to the patients in your specialty? Results of a survey conducted by PatientView in the UK.**

See the patient as a person, and not as a medical problem
See the patient/family/carer as an equal partner
Listen to the patient’s opinions
Communicate in easy-to-understand lay-person’s language
Training courses in how to communicate and interact with patients
Encourage patients to talk freely about ALL their medical worries
Take an interest in the challenges that face the patient in their daily life
Consult the patient’s medical records
Take an interest in the effect of treatment upon a patient’s life
Express empathy with, and understanding of, the patient’s situation
Acknowledge a patient’s need for hope, by sharing relevant information
Behave with respect towards the patient
Make themselves aware of the limitations of the patient’s personal circumstances, and prescribe accordingly

65% 38% 36% 32% 31% 29% 23% 22% 21% 21% 17% 17% 13%
accreditation when asked how they would like regulation to function.

Borman discussed regulation in the market and provided two definitions:

1. Controlling human or societal behaviour by rules or restrictions
2. A rule of order having the force of law, prescribed by a competent authority, relating to the actions of those under the authority’s control.

Both definitions, in Borman’s opinion, contain a bias in that they are each dictated by the rule of law. This legal perspective brings accountability to the system but, at the same time, introduces huge costs.

Regulation applied to CME/CPD should be about encouraging all to strive for the best by providing incentives and raising the standing of CME/CPD in society. There are a number of models that can be applied such as ‘do nothing and let the market rule’, ‘regulate, but keep it local’ and ‘regulate at an international level’. All have their pros and cons, but who pays?

Borman said that, ultimately, the patient pays for the CME/CPD activities performed by their doctors – either financially, so that doctors can learn or, regrettably, by suffering when they don’t. Patients should benefit from the improved quality of care that should result from CME/CPD.

If good regulation exists, the patient knows they are getting good quality, the provider knows they are delivering to the standards expected and, ultimately, clinical care improves.

**Setting standards in CME: an industry perspective**

Is there a difference between industry-supported CME and CME without industry involvement? This was the question posed by Maureen Doyle-Scharff (Senior Director, External Medical Communications, Pfizer). Just under two-thirds of the audience (60%) said ‘Yes’, but Doyle-Scharff said that it should not make any difference: if medical education is about improving patient care, it should not make any difference whether or not pharma is involved.

Since Doyle-Scharff’s role is US-focused, she stated that her presentation would be from a US perspective as well as from an industry perspective. She acknowledged that the US system is not perfect, and that it faces some challenges. Her advice to Europe (and beyond) is to pay close attention to what is going on in the USA because the same questions now arising in Europe regarding accreditation and industry involvement have been, and still are being, debated in the USA.

Doyle-Scharff said that the pharmaceutical and medical device industries have an innate bias when it comes to medical education. The conflict of interest exists because of who they are and is irresolvable. However, as long as it is recognised, ways could be found to manage it.

And so Doyle-Scharff posed a second question – who or what should determine the agenda for CME? In the USA, the great debate is that industry has hijacked the agenda of medicine. However, the only education that exists is paid for by industry, so the question really at issue is: what education is industry prepared to pay for?

Doyle-Scharff said education should be based on true learner needs, not on what sponsoring companies want healthcare professionals to know or what experts think healthcare professionals should know. Education should be designed and delivered in ways that appropriately address those needs. Finally, expected results of the intervention must be measured and the closer these are to patient-level outcomes, the better. This is, however, not easy at a national level. Local interventions get much closer to patient-level outcomes.

Conversely, what should the CME community expect of pharma? From the CME community’s perspective, it has to be about the patient, not the drugs. Admittedly, pharma has an ethical obligation to ensure that physicians understand how to use their drugs in a safe and effective way, but there are other vehicles that allow pharma to fulfill that responsibility and it should not be driving the CME agenda.

Doyle-Scharff said that there are people in Europe who are running scared of transparency but the USA is already living with this, with all manner of disclosures being posted on company websites. The international CME community has to get to the point where it has absolutely nothing to hide. Transparency is key.

**Transparency is key**

Thought should be given to the role that each stakeholder can play in improving global health and patient outcomes. From the industry point of view, a dialogue has begun to learn from past mistakes and leverage past successes.

The International Pharmaceutical Alliance for CME (I-PACME) has been established based on a US model that allows for the exchange and sharing of best practices between industry representatives actively engaged in CME/CPD. The objective is to establish an appropriate path by which to bring forward ideas and engage with the regulatory and CME accreditation bodies.

**European continuous medical evolution – a provider’s perspective**

Thomas Kleinoeder (Chief Medical Officer, KWHC) reviewed standards from the provider’s perspective and compared international, European and national standards, as provided by regulatory bodies such as the European Accreditation Council for Continuing Medical Education (EACCME) and the national states. In adhering to these standards, providers manage the whole process of developing high-quality medical education by
Appropriate education | CME providers should ensure that educational activities have clear learning objectives that are derived from a coherent and objective process that has identified performance gaps and unmet educational needs. The education must be designed to reinforce existing good practice and effect a sustained change in daily clinical practice as appropriate.

Balance | Balance needs to be evident in content, faculty and review. Content has to be developed independently of the sponsor and reflect the full clinical picture within the framework of the learning objectives.

Transparency | All relevant information should be disclosed to the learner so that they fully understand how the content has been developed and presented. This includes the terms of the financial support, relevant disclosures of faculty and organisations involved in the development of the scientific content and the presentation of the programme.

Effectiveness | Post-activity evaluation should measure satisfaction, knowledge uptake and intent to maintain or change behaviour in line with learning objectives. Providers should measure the effectiveness of the education against ‘level 3 – knowledge gain’ of the Moore scale, which should be seen as a minimum standard.

| 1. To provide examples evaluating current experiences.  
| 2. To discuss novel techniques employed in Europe.  
| 3. To outline the principles of performance improvement in CME.  

Kaiser began by providing an overview of how the supervision of CME by the German Chambers of Physicians works. In almost every state in Germany there is a different approach and different responsible authorities for the supervision of CME. There are 17 different Chambers of Physicians, and between 30 and 40 organisations all over Germany that officially deal with the supervision of CME.

Kaiser explained how his own Chamber in Hessen, alongside its many other functions, certifies approximately 12,000 CME activities per year and handles the registration of CME points (a kind of ‘personal account’) for physicians.

With a current membership of just over 30,000 physicians, Hessen has around 15,000 participant days per year. All of the activities are paid for by the physicians themselves, with no external funding.

In Hessen, physicians have to prove a minimum of 250 CME points every 5 years. All physicians in Germany are required by law to do this. Hessen, in line with other Chambers, accredits CME activities by event and not through accredited providers. Kaiser outlined some problems with the current system. First, physicians are able to gain credits from publications, but the definition of what constitutes a scientific publication, or what level of engagement is expected for the award of a CME credit, is not clear. Currently this dilemma is unsolved. The courts may be called upon to decide through legislation.

A second problem is that many doctors do not necessarily attend events for educational reasons, but simply to obtain credits.

Thirdly, education providers in Germany do not follow the correct format when submitting materials for accreditation. This gives the Chambers a lot of extra work if certain considerations are not adhered to. Equally, providers do not submit the achievements of participants in a timely fashion, which means that the Chambers are put under communicating with different stakeholders, considering physicians’ needs, developing content and materials, and administering quality assurance.

Whilst there is the need for localisation, there is also the need for common global standards and understanding. The Good CME Practice (gCMEp) group was established to develop core principles of best practice for medical education. The four core principles are presented in Table 1.

Concluding, Kleinoeder said the gCMEp will develop a transparency declaration form that defines potential conflicts and details what information should be declared to learners as relevant, as well as a standardised evaluation form to capture both qualitative and quantitative feedback.

Borman asked for observations from the floor, in particular from those who had previously voted for no regulation. One respondent said he was very much in favour of the standards as proposed by the gCMEp, but had considerable scepticism about regulations currently practised in Europe. This is partly because of the conflicts of interest that are present in many of the regulators who are often in the business of providing CME themselves and also accrediting competitors, which is problematic in itself. Many organisations involved in regulation are, he said, often unaccountable. Broadly, there is a lot of anti-competitiveness within the CME community and it is a disappointment that CME is not on the scale or quality that is seen in other educational activities and institutions. Three main points stood out for him:

1. The lack of proven effectiveness of CME.
2. The lack of a strong funding channel for CME.
3. The regulation that plays a big part in obstructing initiatives to create really high-class education.

**Session 3: Implementing standards in CME**

The objectives for the final session of the first day were described by the session Chair, Roland Kaiser (Medical Director, Hesse Chamber of Physicians), as threefold:

1. To outline the principles of performance improvement in CME.
2. To discuss novel techniques employed in Europe.
3. To provide examples evaluating current experiences.

Table 1. The four core principles of best practice for medical education, as established by the gCMEp group.
extra pressure to update the ‘personal accounts’ of physicians before the 5-year deadline.

From attendance control to knowledge assessment

Helmut Madersbacher (Chairman of the EU-ACME Committee) took participants through a pilot programme of pre- and post-course evaluation that had been conducted by the EU-ACME (European Urology – Accredited Continuing Medical Education).

The EU-ACME’s main goal is to assist national and international urological societies in the implementation, promotion and organisation of the CME/CPD credit management system among European urologists. This includes the registration and administration of the CME/CPD credit points for more than 18,000 members, 40% of whom were actively collecting credits in 2009. EU-ACME also provides on-site assistance with attendance control in the form of a membership card that can be scanned at events.

Madersbacher asked the audience to record their use of knowledge testing for CME. About one-third had knowledge of post-course evaluation and over a half had knowledge of both pre- and post-course evaluation. He outlined how some delegates were known to attend meetings purely to collect the CME credits rather than the educational content and proceeded to describe a programme that had as a heading “knowledge control instead of attendance control”.

In a pilot study, two European School of Urology (ESU) courses undertook pre- and post-knowledge evaluation by assessing ‘gained knowledge’ using multiple-choice questions (MCQs). Participants were asked to answer the same MCQs before and after the course. Furthermore, 3 months after the course, participants were contacted to ask them about the ongoing benefit of this course.

Although there were variations in responses, 66% and 78% of participants showed improvements after the two courses. Three months after the courses, participants returned a further evaluation form which showed that the overwhelming majority (nearly 90%) had gained long-term benefit in knowledge (Figure 3); however, most said that this gain in knowledge had changed their daily practice only a little. All, however, gained some reassurance from the courses as to what they were currently doing in their daily practices.

Future plans include implementation of this process for eight ESU courses during the European Association of Urology Congress in 2011. Implementation at national meetings may be possible with support from the EU-ACME.

Addressing the needs of GPs

People with diabetes are at a substantially increased risk of experiencing mental distress, particularly depression, compared with people who do not have diabetes. A key report demonstrated that individuals with diabetes have at least twice the risk of developing depression than those without diabetes. Research also shows that depression increases the development of type 2 diabetes.

With this as background, Peter Posel (CEO, QUAIME), in conjunction with the Bavarian GPs’ Association, developed a needs assessment consisting of ten questions on mental disorders associated with diabetes. The goal was to identify knowledge gaps and the need for CME.

Three main knowledge gaps emerged:

1. Lack of knowledge about drug modes of action in modern therapeutic concepts.
2. Lack of knowledge about drug interactions, especially in elderly patients with chronic diseases taking more than three drugs per day.
3. Barriers in communication between specialists and family physicians.

Using virtual classrooms, online clinical cases and online lectures, Posel showed that acceptance and success

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Figure 3. Three-month evaluation of two European School of Urology courses.
are based on solid structures providing higher average quality, clearly defined objectives and, ultimately, strategic advantage. The goal of this approach is not only to improve GPs’ knowledge but also to initiate a CPD process for each individual participant. The key aims are to improve patient care and close the gap between GPs and specialists by learning from each other.

Following the success of the pilot study, the programme will be rolled out to 1000 GPs in 2011, with a pre-test, post-test and a 3-month follow-up.

**CME in Bulgaria: example of a difficult evolution**

Todor Popov (Union of Bulgarian Medical Societies [UBMS]) began with the declaration that he is a strong believer in the future of CME in Europe. However, he presented a cautionary tale of how CME can be abused.

Popov described how a national structure for CME was set up in Bulgaria in 2001 by the Union of Scientific Medical Societies of Bulgaria (USMSB). This was endorsed by the Ministry of Health and an accreditation council was set up. Launched in 2002, the system ran smoothly, and an agreement was drawn up between the USMSB and the Bulgarian Medical Association (BMA) to run a joint programme for the implementation, evaluation and control of CME activities. Over the following 3 years, a total of 97 events were accredited and thousands of certificates were issued.

Then, in 2004, the BMA saw the opportunity to make money out of this system and withdrew from the agreement with USMSB to try to establish a monopoly in CME. The BMA transformed the system to make it quite basic. They removed the accreditation council as they thought this would make the process more efficient. But this actually removed the quality control of CME. They started awarding points on the basis of contracts signed by the providers saying that a percentage of the provider’s revenue would go to the BMA. It became a system that had no value for the doctors it was supposed to benefit.

Popov said the renaissance of the CME system in Bulgaria was brought about by the reactions of the medical community, the general public and the media. When doctors realised that the certificates issued by the BMA were worthless, they looked for an alternative and this came in the shape of the pharmaceutical companies who, having also recognised the flaws in the system, began to manage CME themselves.

With international support, primarily from the Rome CME/CPD Group and the European Union of Medical Specialists (UEMS), pressure was brought to bear via the Sofia Declaration and the BMA appointed new leadership. A memorandum of understanding was drawn up between the USMSB (now known as the UBMS) and the BMA. The organisations will work together in the field of CME to develop an optimal contemporary system. The UBMS will be responsible for assessment of the quality of CME provision while the BMA will register the credits received by individual physicians.

The Bulgarian system should now provide good value to the doctors, the patients and the wider Bulgarian community. Popov also hoped that by sharing the experience of his country, it would avoid the same errors happening again anywhere else.

**Workshop: Measuring outcomes and performance improvement in CME**

Suzanne Murray (President and Founder, AXDEV Group International) began her workshop on ‘measuring outcomes and performance improvement’ with a question for participants: “Prior to attending this conference, what was your understanding of performance improvement?” The lack of audience response spoke volumes.

Murray provided an example based on the use of spirometers in patients with chronic obstructive pulmonary disease. Although inordinate amounts of money and time are spent on courses for physicians aimed at training them on the correct use of spirometers, such courses have not been widely adopted. When research was carried out into this phenomenon, it was discovered that physicians have a particular barrier: even when an appropriate assessment of gaps is conducted and a gap identified, family physicians struggle to interpret the actual results and to make a clinical decision with their patient.

Once a programme was designed to help physicians look at different types of spirometric results that then translated into a clinical decision, their confidence increased and therefore their willingness to adopt the procedure with their patients increased.

Murray said that examination of the traditional view of educational events showed it to be a series of individual, ad-hoc episodes which, she argued, had little impact on changing behaviour or improving clinical performance. The future direction for education, she said, requires a greater focus on:

- competence: how one can or cannot demonstrate the acquired knowledge and skill in various scenarios
- performance: how one can or cannot demonstrate that one is competent and DOING the tasks in the workplace
- personal and collective learning: communities of practice and healthcare teams
- inter-professional learning: teams and communities as the focus of our educational mission and measurement strategies
- systems-based care: educating health professionals to see their professional roles and responsibilities as contributing to patient care and the systems within which they work.
The evolution of education from CME through continuing health education and CPD to performance improvement is reflected by the impact that each of these activities has had. As education has developed so it has had an effect on physicians that goes beyond simple knowledge gain and directly impacts on competence, performance, patient health and community health.

Murray said that the CME community needed to validate the value of CME, but in order to demonstrate its value, the community must understand when and why education is the correct solution. An educational intervention, she said, is not always the right intervention.

Murray hoped that her presentation would inspire the audience to go beyond the status quo, to take thinking beyond events and tools, and try to align a strategy to CME that will impact clinical performance.

Session 4: Question time

Day two began with a session devoted to questions from the floor put to a panel consisting of stakeholder representatives from industry, providers and accrediting bodies, complemented by a professional medical educationalist.

Chaired by Robin Stevenson (Immediate Past-President, European Board of Accreditation in Pneumology), the panel consisted of Jan de Monchy (Chairman, UEMS Section and Board Allergology and Clinical Immunology), Carry Pesch (Senior Operations Director, prIME Oncology), Jonas Nordquist (Director, Medical Case Centre, Karolinska Institute) and Maureen Doyle-Scharff (Senior Director, External Medical Communications, Pfizer).

Wolfgang Schmidt (Physicians World Europe) asked for the panel’s opinion on the future role of e-learning in Europe and its accreditation. Nordquist said he does not believe there is a magic bullet and that e-learning has been approached with a bit of hysteria. Learning is much more complicated than just having a simple tool.

There are a number of things that need to be addressed ahead of choosing the appropriate technology, not least the learning objectives. But Nordquist said he recognised that with respect to accessibility, e-learning has a very important role to play.

Doyle-Scharff said that as an assessor of grants, she too often sees proposals that jump immediately to an e-learning platform although there has been no work done in terms of needs assessment, gap analysis, etc.

A discussion followed in which the effectiveness of e-learning was explored. It was pointed out that there is a large evidence base, especially in the USA, demonstrating its value. A member of the audience added that a blended learning approach works well.

Discussion moved to the value of CME credits and the reasons that doctors participate in CME. It was recognised that many doctors participate in CME activities purely for the educational value and not for the credit and, as Europe has only a few countries with a mandatory requirement, it was questioned whether it was worth having programmes accredited in the first place.

Doyle-Scharff said she believed the credit system provides some assurances. It puts a system in place that should reassure learners that the information being presented as education is evidence-based, balanced and free of bias.

de Monchy said that credits generally attest to the quality of the product and so, in his opinion, accreditation is worthwhile. Borman, from the floor, raised the issue of weighting the award of credits to programmes as well.

Pesch responded on this point with reference to a recent gCMEp Group meeting, saying that it is important that standards are accepted and adhered to in order to build quality in CME. The application of more or fewer credits comes second to the development of good-quality education.

Robin Stevenson returned to Nordquist for his opinion on CME providers: what deficiencies would he recognise in CME providers today? Nordquist said that learning objectives are absolutely key. He compared what is currently happening in CME to experience at the undergraduate and residency level, where the discussion is about blended curricula and the transfer of knowledge into reality. He pointed out that in residency, training time is a proxy for quality. Five weeks in rotation in the Emergency Room is considered to provide a resident with mastery of all the appropriate skills required, even though such skills may not necessarily explicitly be encountered. He said that CME providers therefore need to look at learning objectives and align programmes appropriately.

The Chair then raised an anonymously submitted question about what lessons Europeans should take from the experiences in the USA. de Monchy had learnt that mandatory CME is important. Pesch had learnt the need to start collaboration with all parties involved as early as possible. But Nordquist warned against seeking out best practice in the USA and bringing it to Europe, saying that context is a very important consideration. One intervention does not necessarily travel well to another continent.

Further discussion highlighted that a system of provider accreditation is not in itself unsuccessful. However, if systems are not in place to review providers and their standards regularly, then it would be the worst kind of franchising and doomed to failure because of human nature. So the lesson learnt is that Europe needs to implement robust systems to assess the capabilities of providers on a regular basis.

One further lesson from the USA is that if the European CME community does not prove to its political masters...
that it can manage its own activities to a reasonable standard, then they will take control and tell the community what to do. Europe needs to move forward to demonstrate that there are very clear standards that can be maintained and applied right across the board.

Session 5: New developments and relationships in CME

Session Chair Alfonso Negri (Technical Scientific Secretary, Italian Federation of Scientific Medical Societies and Chair, Rome CME/CPD Group) began this session, exploring the changing relationships in the evolving European CME environment, with an examination of the market in Italy.

Changing relationships in Italy

Negri explained how, in 2010, the Italian Ministry of Health had decided to progress a project that had been in development for about 2 years. From 2002, 12,000 providers had organised over 400,000 events in 8 years, each being individually accredited. However, the system was to change, and from now on only a few hundred providers would become accredited providers. Following a successful probationary year, they would be accredited for a further 5-year term.

CME has been a legal obligation in Italy since a law was passed in 1999. However, after 8 years of event accreditation, there was still a lack of a clear objective, and even though the system has been mandatory there are no incentives and no sanctions.

With the introduction of this new system there will be rigid criteria for providers, with a requirement for needs assessment, measurement of outcomes and clinical governance.

However, with all these changes there is an additional problem in Italy as each region has its own existing CME system, so providers need to decide whether to be a regional or national provider.

Spanish CME is growing. Are we heading in the correct direction?

Arcadi Gual (Coordinator of the Professional Area of the Spanish Medical Council and General Secretary of the Spanish Accreditation Council for CME [SACCME]) gave details about the Spanish system in which they run an event-based CME accreditation system rather than provider accreditation. It can be accessed in two ways – first through the health administration of the 17 autonomic communities (doctors, nurses, pharmacists, etc.), and secondly through SACCME/SEAFORMEC (Sistema Español de Acreditación de la Formación Médica Continuada) under the supervision of the Spanish Medical Council (CGCOM) – although this second route is only for physicians.

It is not clear what use CME credits could be put to, nor is it clear why or how industry should be interested in the development of CME. In Spain, industry, directly or indirectly, is usually the CME provider, which is acceptable as long as the infiltration of bias is controlled. On the other hand, it seems that the Spanish administrators want to play a role as a regulator, which is also acceptable as long as collaboration continues with the medical professionals whose role is also in development.

The 52 regional medical councils, under the umbrella of the CGCOM, have approved the VPC process – the periodic validation of professional registration, which is the first experience of professional self-regulation in Spain:

- certification of good practice
- declaration and promise of health maintenance
- certification of employer
- a minimum requirement of CME credits.

This process was approved in 2009 and will be valid for a period of 6 years.

The four elements of the VPC process are critical to its success and currently its future appears optimistic. The collaboration of the professionals and the organisations is guaranteed, but it would also benefit from other stakeholders (medical societies, patients, health administration) getting involved.

Commercial support for CME in Europe

Bernard Maillet (Secretary General of UEMS-EACCME) acknowledged that there were a lot of things happening in European CME but said he wanted to concentrate on the important issue of commercial support. Standards exist for commercial support and regulations are in place to ensure the independence of CME/CPD activities by preventing bias. These regulations are national, European and global, and include medical association guidelines and industry codes as well as legislation.

Maillet identified satellite symposia as a special case where objectives need to be clearly assessed, as the danger of bias is evident. The most common difficulty with symposia is in establishing a fully independent faculty.

CME without industry support is nearly impossible

Commercial support accounts for more than 60% of CME/CPD in Europe and the USA. It is essential to assure access of physicians to quality CME/CPD activities. In Belgium, a new organisation known as Mdeon has been formed to act as an independent body regulating the sponsoring of events. It is mandated by government
and is organised by the three main partners: industry, pharmacists and physicians.

Maillet concluded that CME without industry support is nearly impossible. Whilst, therefore, an industry ban is not a solution, clear rules will make the system much more effective.

### Needs assessment as an educational tool

Philipp Leuschner (Medical Scientific Liaison Manager, EIMSED – European Institute for Medical & Scientific Education) spoke about needs and outcome assessment as an opportunity to establish relationships between CME providers and healthcare professionals.

Leuschner described the educational planning process as a needs assessment (Figure 4) followed by an establishment of the learning objectives, then content development, determination of the type of intervention and, finally, evaluation. Evaluation, he said, should always feed back into future needs assessment. This should be a dynamic process.

The traditional approach for needs assessment was to approach the experts, but latterly the learners themselves are being asked about their learning needs. However, on their own, neither of these is sufficient. A combined approach including all stakeholders is now the preferred option.

Leuschner said that since everybody brings their own bias, including as many stakeholders as possible helps to even this out. There are some challenges associated with this and one of these is the realisation by the learner that a need exists. Awareness of a personal performance gap is the first step in the learning process but this requires the learner to discuss their challenges openly, showing a professional vulnerability.

Generating awareness of individual needs in learners motivates them to follow the intervention more closely. This process also motivates speakers because they get direct feedback from the audience, which in turn allows them to target presentations to the audience.

In summary, Leuschner reinforced the importance of needs assessment, carrying it out up front but also including it in the intervention phase to corroborate the results of the initial needs assessment.

### Value to public health and business value to commercial supporters

Thomas Kellner (Global Leader Medical Education, MSD) began by saying he thought the ECF had shown that huge progress was being made in the way that CME was being discussed. But he said there was work to be done in delivering an appropriate match between the value of CME to public health and the business value of commercial support.

Kellner presented the results of a survey that he had undertaken in the previous months amongst 47 CME stakeholders, each of whom had at least 10 years’ experience in CME.

The survey demonstrated both differences and similarities between Europe and North America. The main difference

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Figure 4. Needs assessment – stakeholders.
estimated for the next 5 years was that in Europe, budgets might increase whereas in North America the opposite is expected (Figure 5).

Within what he called promotional CME (company-provided medical education) a similar effect was evident. Restrictions were expected to increase in both environments. Another response not detailed was that stakeholders unanimously expect company-provided medical education to be eliminated within the next 5 years in both environments.

Kellner raised a controversial point regarding financial interest and bias. Where industry and commercial providers are concerned, he said, bias is expected because they have a commercial interest. But, while it is assumed that academic centres and professional associations are free from bias, questions needed to be asked regarding funding and potential career paths of these two institutions. Kellner said it would be difficult to have any stakeholder who has no bias in his decisions.

Added to this, there is critical public opinion that is shaped by people who are lobbying for a specific interest. It has, he said, become very popular to point the finger at the ‘bad’ commercial side and to be positive about the so-called non-commercial side. But, he claimed, public opinion is often incorrect and not related to CME, it is related to bias – the bias of those lobbying against industry.

Kellner posed two questions:

1. **“Is accreditation a valid and reliable differentiator of education compared with promotion?”**

   The audience suggested that while this helps start the discussion with stakeholder groups who are not familiar with the differentiation between promotion and education, at the moment, regulations are too fluid in a lot of countries to allow accreditation to act as a reliable differentiator.

   **2. “What criteria can be applied to better differentiate education from promotion?”**

   Promotion has a clear definition, with a primary intent to increase market share and sales, although it does require a level of knowledge, competence and skills of healthcare professionals in order to use the products.

   Education has the primary intent to improve the knowledge, competence and skills of healthcare professionals in order to improve patient outcomes, although it cannot be excluded from having an impact on sales of a specific product.

   The term ‘promotional education’ is therefore misleading.

   What, therefore, is the role of the industry? Kellner believed that industry cannot be a provider of CME. Industry can be a supporter and collaborator but not a provider because of the inherent conflict of interest that is created by commercial interest. Regulators, however, need to recognise and respect the commercial responsibility of industry towards shareholders, although this does not imply a direct link between the educational support objectives and sales objectives of a product.

   The other critical factor was the business of medical education administration management. This could become a burden for providers and may reduce innovation and the evolution of education. However, it could produce value whilst reducing risk and ensuring appropriate design if it had the primary objective of supporting effective education and not quantitative administration targets.
Medical education managers understand education and provide a lot of value to the process of development and delivery of medical education. In addition, they help to educate stakeholders within a company on how to do it right. Kellner proposed that there is an urgent need to make this a discipline.

Kellner concluded by saying that industry cannot exist without fulfilling public health needs. He saw a strong value in public/private partnership and said it was difficult to imagine how CME could work without it.

Session 6: Learning about learning

Session Chair Jonas Nordquist (Director of the Medical Case Centre, Department of Medicine at Karolinska Institute, Stockholm) said that his role is to make teaching and learning more interactive. Nordquist spends much of his time involved in undergraduate education and residency training, and acknowledged that there is a missing link between what is done in medical school, residency training and CME. The Karolinska Institute invests heavily in educational activities but, he asked “how do we design those activities in such a way that we can elicit high-quality learning?”

The objectives of the session were to identify some basic key adult learning principles based on educational research and to enable participants to discuss how these principles translate into designing educational activities in the domain of health professional education.

Learning, said Nordquist, is to understand something in a qualitatively different way. There are some forms of learning that are better than others. Measuring retention rate would normally show a big difference between what is remembered immediately following an intervention and what is learnt and recalled a few weeks later.

Nordquist described how in the 1970s there were some important discoveries in the world of education at the University of Gothenburg. They identified a surface approach to learning and a deep approach to learning (Table 2). In the surface approach, readers try to remember as much as possible of the individual components in that particular text. This results in a poor retention rate. The deep approach involves reading the text and trying to understand and evaluate the structure of the text – an holistic approach to learning.

Some people have a tendency to use the surface approach more than others but it is possible to move people from one approach to another, a beneficial consideration when designing education.

Nordquist explained that most learning environments are designed in the same way as was used hundreds of years ago and they clearly correlate to the surface approach to learning.

Nordquist put a simple question to the audience: what makes interesting learning? Responses were varied. According to delegates, learning should:

- have practical application
- be given by passionate educators
- be a pleasurable process
- be entertaining/enjoyable/engaging.

Nordquist disagreed with this last point, saying that some students are terrified of being engaged: preferring instead a dark lecture theatre where they just sit and listen. The thought of becoming engaged actually disengages some students. According to Nordquist, learning should:

- be relevant
- be thought provoking
- provide perceived improvement of oneself
- be self-fulfilling
- be concept changing (the ‘aha’ moment)
- be challenging.

Adult learning principles

Malcolm Knowles is often referenced as the godfather of andragogy, which is a learning strategy focused on adults. He developed six principles in total, but three are important to CME. First, education should focus on the ‘need to know’; then, recognition and the importance of previous experience and previous knowledge are critical; and finally, one must actively engage and interact with the learning.

How do we design learning?

Again, this question was put to the audience. The consensus was that needs assessment leading to the setting of objectives establishes the content of learning, whereas the audience’s way of thinking should be used to suggest the type of platform – whether e-learning or event-based.

Blended learning came about after learning moved from the practical environment into universities and colleges. However, learning became all about practical application and so blended learning became a reality combining theoretical teaching with practical skills.

Nordquist concluded by saying that a blended curriculum is probably what the CME community should be aiming for.
for, involving different teaching and learning activities. In addition, the power of previous experiences and previous knowledge in influencing how learners learn should not be underestimated.

**Session 7: The CME unsession**

The goal of this session was to ensure that the meeting had met the needs of the audience in the room. Session Chair Lawrence Sherman (SVP Educational Strategy, Prova Education) proceeded to conduct a review of aims, interventions and assessments for the ECF to see if it had achieved its objectives.

When he asked whether anyone had come with a burning question that had not been answered during the course of the meeting there were no responses from the floor, but Sherman revealed that he had received a comment from an anonymous participant who asked: is there a role for the European Federation of Pharmaceutical Industries and Associations (EFPIA) in setting some standards and principles or even in being a source of funding by collecting from all of its members in CME?

Kellner said that CME is not recognised by EFPIA so there really is an urgent need for this to be addressed. Secondly, there are no available funds for promotion so Kellner did not see why EFPIA or anybody else should provide a central pot for funding CME. Maillet suggested that EFPIA may currently be working on something about CME and compliance.

Doyle-Scharff said that the various trade associations around the world have far higher priorities to deal with relative to their various members and to the industry in general. CME is really low on that priority list, but that does not mean that they are not looking at addressing it. In Doyle-Scharff’s opinion, when they do get around to reviewing CME they do so in a fairly superficial way and don’t get to the heart of some of the things that we have talked about over the past 2 days.

Sherman examined demographically analysed responses of some of the audience response system questions posed over the 2-day meeting, in order to promote discussion.

Revisiting a recurring theme of the meeting of whether there is a strong future for European CME, various opinions were aired from all stakeholder groups. Some agreed that as accreditation is still not easy in Europe it will remain a fringe interest. But one delegate said: “If we cannot solve that, then there is no future for European CME whatever we do here”.

This view was supported by another participant who believes that European CME will remain small and fragmented. As a learner, he wants to feel that he has the right to study resources from the Karolinska Institute, Italy, Spain, America, etc. – and take the best learning. But the current regulatory regime in Europe prevents that.

Sherman pointed out a caveat, which is that anyone can partake in medical education anywhere. Whether they can then claim CME credits is another question.

**Meeting close**

Eugene Pozniak closed the meeting by reviewing the aims for the ECF in the coming year, including the prospects for a European CME journal and the future activities of the Good CME Practice (gCMEp) Group. The 4th Annual Meeting will take place in Amsterdam, The Netherlands, on 10–11 November 2011.

**References**


**Further reading/online resources**

Further information can be found at the European CME Forum website [www.europeanCMEforum.eu](http://www.europeanCMEforum.eu)

**Documents**


**Websites of ESABs and related medical organisations**

Accreditation Council of Oncology in Europe (ACOE) [www.acoe.be](http://www.acoe.be)

European Urology - Accredited Continuing Medical Education (EU-ACME) [www.eu-acme.org](http://www.eu-acme.org)

European Accreditation Council for CME (EACCME) [www.eaccme.eu](http://www.eaccme.eu)

European Board for Accreditation in Pneumology (EBAP) [www.ebap.org](http://www.ebap.org)

European Board of Accreditation in Cardiology [www.ebac-cme.org](http://www.ebac-cme.org)

European Federation of Pharmaceutical Industries and Associations (EFPIA) [www.efpia.org](http://www.efpia.org)

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

European Union of Medical Specialists [www.uems.net](http://www.uems.net)

General Medical Council (GMC) [www.gmc-uk.org](http://www.gmc-uk.org)

Royal College of Physicians (RCP) [www.rcplondon.ac.uk](http://www.rcplondon.ac.uk)
The Good CME Practice Group

The aim of the Good CME Practice Group is to develop standards for implementation by the European CME provider community to ensure high quality and effective learning programmes.

At the Spring Meeting in London in May 2010, participants of the gCMEp Group summarised and agreed the current working practices in Europe and agreed to align the standards of Good CME Practice along 4 Core Principles.

**Appropriate education**
Educational programmes should address pre-identified educational needs.

**Fair balance**
Educational programmes should be independent of the sponsor and demonstrate fair balance.

**Transparency**
Relevant relationships between individuals and organisations, funding support and sources and generation of content should be transparent with full disclosure.

**Effectiveness**
Programmes should be reviewed and evaluated for their effectiveness.

The group is developing practical guidance to CME programme development and delivery with templates to support providers in attaining and maintaining standards.

The Core Principles and supporting guidance will be finalised following a formal consultation process with other stakeholder groups. More information will be presented and published throughout 2011.

**Further information**
www.gCMEp.eu
3rd Annual Meeting of the European CME Forum
In-depth report from a meeting held in Berlin, Germany
16–17 November 2010
a KeywordPharma Conference Insights review