



**UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES
EUROPEAN UNION OF MEDICAL SPECIALISTS**

20, Av.de la Couronne, Kroonlaan
B-1050 BRUSSELS
www.uems.net

tel: +32-2-649.5164
fax: +32-2-640.3730
e-mail: secretarygeneral@uems.net

Draft
D 0401

**EACCME®
European Accreditation Council for
Continuing Medical Education**

Report of the Meeting of the Advisory Council for Accreditation of the UEMS held in Brussels, November 29th 2003

1. Opening welcome of the participants.

Dr. Hannu Halila (FIN), President of the UEMS, opened the session and thanked the delegates for being present. EACCME® members are the national CME regulatory bodies, but representatives from the European Boards and Societies had been invited as well. For the AMA Dr. Dennis Wentz was observer.

The composition of the Executive Committee of the UEMS is:

President:

Dr Hannu Halila (FIN)

Secretary-General:

Dr Bernard Maillet (B)

Liaison officer:

Mr Len Harvey (UK)

Treasurer:

Dr Vincent Lamy (B)

Managing Director:

Mrs. Bénédicte Reychler (B)

Secretariat:

Mrs. Nathalie Paulus (B)

The members were briefly introduced.

2. Approval of the report on the meeting on November 23rd 2002 (D0305).

This report was approved unanimously.

3. Update review of national situation (D0305 Annex).

This document is one of the most important produced by the UEMS every year and due to its importance it is proposed do consider it as a distinct document and not as an annex any longer. Dr. Len Harvey is the author of this document and is introducing this item by asking to the different delegates to give a short overview of the changes (if there are). He also asked the

delegates to send him an e-mail version of these information if the changes are quite important so that written statements can be drawn.

Based on this information Dr. Harvey will compile an overview of the 2003 situation.

Completely voluntary CME:

Doctors are free to decide for themselves in the Scandinavian countries, Portugal, Luxembourg and Greece. In most of these countries the National Medical Associations have a system in place to monitor CME activities of their members, but compliance is variable. Finland is in the process of setting up a National Accreditation Council.

Semi-mandatory systems:

Semi-mandatory systems, regulated by the profession are operational on a national scale in the United Kingdom and Ireland. There is no re-licensing, but compliance with CME standards is necessary, for instance for contracts with hospitals and insurances.

The same situation applies to Germany and Spain, but there the regional Medical Associations are in charge of the CME accreditation and awarding of CME credits. In Germany a unified credit system has been accepted.

Legal Systems:

In the Netherlands and Austria doctors are required by law to maintain their professional competence.

The professional organisations are running a CME accreditation and credit system, but the link with the legal requirement leading to re-licensing has not been made yet. In Switzerland the legal system is run by the profession which implements the legal requirement.

In Italy a legal system is in place with re-licensing, run by the Ministry of Health. There is no quality control yet. The profession is negotiating a role in the quality control of CME.

Austria : There are no changes compared to last year. The system remains legal and allow also Long Distance Learning programs. Recertification organized by the profession.

Belgium : It remains a voluntary system based on a financial bonus for participation. There is hope that the contacts for mutual recognition of the credits could be improved by the recent change in the President of the Accreditation Authority.

Denmark : It remains a voluntary system. There are no plans for introducing recertification. The financing of the CME/CPD is realized by a CME fund. Nearly 95 % of the GP's and specialists are participating to the program.

Finland : a Working Group has been created to look at the future of CME. Some funding has been scheduled by the government to finance CME and the process is run by a Professional Body.

France : (Although there was no official French delegate Dr. Delarque gives some information) The system remains voluntary. There is a mandatory national accreditation system for the hospital based on the speciality. The system is run by the Ministry of Health.

Germany : Voluntary system. The accreditation is based on the State Medical Chamber (Landesärztekammer) together with Scientific Societies, but from January 1st 2004 a mandatory system will be introduced for a period of 5 years. There will be a financial penalty (10 % of fees) if non participation. The system will be run by the Bundesärztekammer together with Professional Boards and Medical Associations.

Greece : Nothing changed. CME remains voluntary and there are a lot of discussions concerning the funding.

Iceland : There is no accreditation system now. Next year may be it will start. The system will be run by the Iceland Medical Association with the support of the University of Iceland. It will start with a voluntary system without legal issues of the Government.

The funding is based on the payment of two weeks for formal CME activities, travel and day life expenses.

Ireland : not present.

Italy : The system is mandatory and run by a Commission of the Ministry of Health.

The FNOMCeO can be a provider for ethics and civil rights. Doctors have to collect 150 credits in a three year period so in 2006 a first check will be possible. There are two topics that the Commission indicates as to be followed in the CME program by all health care professionals so there are about 1000000 people involved (doctors, pharmacists, veterinaries, nurses and so on...). Due to the Devolution law, the CME is partly devoted to the regions. The system is based on a kind of provider. The quality of the providers is assessed not the quality of the events. One of the problems is the influence of the industry.

Luxemburg : not present (completely voluntary system).

Netherlands : No changes.

The system is mandatory and is not based on the CME directly but more on the practice so retired people having too less activities can be excluded. Per speciality the Professional Societies run all their own system and there are somewhat 40 different secretaries. Some people would like to coordinate the system and harmonise it (keep) (t) (super) (simple).

Norway : Since 1992 the Health Authorities are responsible for training and medical education. There is a shift for CME to the Norwegian Medical Association. Basically there are no changes except for the GP's where the system became mandatory with a lower remuneration for non participation. There is no funding (evaluated for 700 Mn €) and the costs for CME are covered by the individual doctor. There is a pilot project in some specialities (gynaecology and pathology) to have also a mandatory system.

Portugal: not present (completely voluntary, no registration).

Spain : **The CME is not mandatory. There are three systems in Spain : a residual, one from the Ministry of Health** and one organised by the Spanish Medical Association (Consejo General). This last one is the only working and running system for the moment. Contacts between the SMA and UEMS (EACCME) lead to the signing of an agreement on mutual recognition of credits.

Sweden: not present (will send a written report of the actual situation and changes)

Switzerland : not present (mandatory system run by the profession).

United Kingdom : CPD is not legally mandatory but strongly voluntary. It is firmly linked to recertification and part of an extended system of "peer review" by filling in a portfolio of activities with appraisal and revalidation. This is organised by the Royal Colleges with an umbrella organisation the "Academy of Royal Colleges". This is independent of the government and also fighting with the government. There are some worries about the governmental intentions concerning CPD. The government tries to redirect doctors in their carriers based on this.

Cyprus (Greek part): The Cypriot Medical Association controls the CME program. People have to collect a list of activities attended in 2004 but this will be the last year of voluntary CME. From January 1st 2005 the system will be mandatory by a special law. The CMA will still control the running. The Government sponsors large events. Cyprus would like to promote a more uniform system of CME throughout Europe.

Czech republic : Nothing new. The Czech Medical Chamber is the National Accreditation Authority. There is a new act on postgraduate education that would make the system mandatory. There is no recertification nor does there exist a strong control system.

Hungary : There was a five year mandatory system where doctors had to collect 150 credits in a period of 5 years that will end in 2004 and so an evaluation could be done. The system was run by the Universities and financed by Universities, Companies, Scientific Societies and Private funding.

Romania : not present.

Slovakia : A 5 year mandatory system started this year and the system is run by the Slovakian Medical Chamber, the Universities and the Scientific Societies.

Slovenia : There is a mandatory system run by the Slovenian Medical Chamber based on practice and mandatory CME. It is a Provider accreditation done by Professional Bodies, the SMA and Scientific Societies. There is now an assessment of what happened before.

Turkey : Not present.

USA : At this level, the President asked Dr; Dennis Wentz to present the actual status in the United States but first wanted to thank him for the fantastic collaboration between the AMA and the UEMS now that he is retiring.

There are somewhat 715000 doctors participating in the system.

The AMA shares common values with associated organisations such as Malaysia, Canada, Georgia, Brazil, Mexico, the ACCME and of course our mutual agreement AMA-EACCME.

Also in the United States the system can be different from State to State and the CME is mandatory in 40 of the States.

The AMA has eliminated the term "hour" and replaced it by "credit".

Credits can be also attributed to LDL and peer review.

Also in the United States funding is a problem. Now the events have mainly a pharmaceutical industry commercial support but this is worrisome.

The ACCME runs a provider system with 700 national providers and somewhat 1900 local.

There are some standards for commercial support that could be found at the website of the AMA :

AMA-assn.org/go/ethicalgifts.

At this stage the Presidents asked the Boards to present their comments :

EBAC : The first annual report has been published.

The EBAC-accreditation is complementary to the National Accreditation Authorities.

3 evaluators follow strict rules to evaluate the events on an independent way.

LDL : more than 20 web modules have been approved, not all from ESC.

2 CD-ROMs have been evaluated.

EBAC stresses that they are a non profit organisation.

EBAP : Follows the same policy as EBAC.

FECS : Have the Accreditation Council for Oncology in Europe.

FENS : Follows the same policy.

4. Signing of the agreements between the UEMS – EACCME and the relevant national authorities of Spain and Cyprus.

By starting the EACCME it was the aim of the UEMS to help the European doctors in the exchange of credits between the different European countries and the different specialities by handling as a clearing house. When starting his office as Secretary General in October 2002 Dr. Maillat experienced some difficulties on mutual recognition of credits between the different member states of the European Union. Dr. Leibbrandt (the past Secretary General) tried to convince already the authorities about the usefulness of the EACCME and the fact that this organisation could diminish the workload by accepting each others credits. This was done on a written way so the actual Secretary General would like to contact each member state individually and promote harmonisation of the CME process. Finally everybody stands behind the same basic quality criteria that are mentioned in the UEMS charter on CME (D0.....).

The first of these contacts lead to the signing of the agreement between the UEMS – EACCME and the Spanish Medical Association and Cyprus Medical Association.

This process is an on going process and other countries will hopefully follow this initiative.

5. Working Group on Long Distance Learning (D0355).

This topic was headed by Dr. Harvey who wanted to say something before concerning the current play of the situation in the EC on Mutual Recognition and the Doctor's Directive.

The 10 new countries signed a document that mentioned the actual 52 existing specialities in Europe. Most is done by DG Internal Market which is mainly interested in trade policy and nothing to do with health care. A lot could be done to improve the impact of SANCO as leading DG for Health Care.

The first meeting of this working group studying the possibilities of medical education at distance and proposing some advice was a very interesting one. More problems were opened than answered. Some pressure is coming from the field as to take a policy concerning LDL. A survey will be done by a questionnaire about the LDL activities in the different member states so that we have an overview what is the acceptability of LDL. Some maximal amount of accreditation by LDL is also proposed (about 80 %). The message would be only give credits as learning is going on like on the SKOLAR system in the States.

Most of our accreditation systems expect to have a balance in local events, meetings, learning and learning in peer groups.

The UEMS Sections and Boards can be a very important player in the evaluation of the Quality of the programs.

6. Practical operation of the EACCME (D0217).

This point is of course the main topic of the meeting.

The Secretary General gave an overview on the State of the Art now. One of the most striking changes in 2003 is the introduction of the sliding scale for the fees for administrative costs to the providers of events. This point raised a lot of reaction from the European Scientific Societies and European Boards. These organisations do evaluate events on CME in their respective fields and these evaluations create costs. Who pays who. There are different pathways for the accreditation. One single system would be ideal. The Secretary General stresses the importance of the National Accreditation Authorities in the process, who sometimes have the feeling of being shortcut when they are not involved. He illustrates this with some examples that happened last year and wants to bring both parties together by trying to have a mutual agreement with all the National Accreditation Authorities in Europe. Of course this is a long lasting activity and started with Spain and Cyprus. Other countries will follow.

The European Board for Accreditation in Cardiology (EBAC) is a very active and important organisation who realises the evaluation of events in its field based on high level quality criteria that are also governed by the UEMS (EACCME). They have a network of highly skilled evaluators that have a large expertise in this field. Also the Federation of European Cancer Societies (FECS), the European Federation of Neurological Sciences (EFNS) and the European Board for Accreditation in Pneumology (EBAP) work on the same way. These are non-profit organization that ask some fee to cover the cost of the procedure. This point raised a lot of questions. Especially when there are large events with large audience the fees can be higher and this can lead to unclear financial situations. There is no uniform amount of money for the fee to cover the costs in the different Boards and Societies. The sliding scale adopted by the UEMS for the EACCME since april 2003 was also largely debated at this point.

Looking at the daily practice of the accreditation process the terms in which requests have to be submitted is very important. Many requests are late (some even after the event took place) so that the evaluation is made impossible. A four months term before the date of the event has to be respected by the organizers and three weeks for the evaluation by the National Accreditation Authority cq Section or Board.

Some problems remain in those events where no section or board is involved. Who has to be asked for evaluation. A more pragmatic working is proposed and this was also stressed by the FECS.

7. Any other business, Next meeting (Saturday November 27th 2004).

In conclusion, the President stressed that the debates in the meeting were mainly concerning the practical working of the accreditation. Of course this is also the aim of this kind of meeting of the Advisory Council for CME of the UEMS. We have to remember that the EACCME is only 3 years young and that most of the events does not give any problem. To conclude he prompted that the EACCME realises that there is a consensus on the need in an European accreditation.

The next meeting of the Advisory Council on CME of the UEMS will be held on Saturday November 27th 2004 in Brussels.

List of Participants.

FULL MEMBERS

AUSTRIA	Pr Wolfgang FEIL	
DENMARK	Mrs Helle NIELSEN	Danish Medical Association
FINLAND Duodecim	Dr Juha Pekka TURUNEN	Finnish Medical Society
GERMANY Landesärztekammer	Dr J.W. WEIDRINGER	Bayerische
ICELAND	Dr A. VIKINGSSON	Icelandic Medical Association
ITALY (FISM)	Dr Giorgio BERCHICCI Dr Alfonso NEGRI Dr Riccardo VIGNERI	FNOMCEO Italian Federation of Scientific Societies Italian Ministry of Health
NORWAY	Mr Einar SKOGLUND	Norwegian Medical Association
SPAIN	Dr Helios PARDELL Dr Guillermo SIERRA	Consejo General de Colegios Medicos Consejo General de Colegios Medicos
THE NETHERLANDS	Dr Cees LEIBBRANDT (KNMG)	Koninklijke Maatschappij tot Bevordering der Geneeskunst
UNITED KINGDOM London Edinburgh	Dr Michael SHOOTER CPD of the Dr Ian STARKE Dr Mike WATSON Mr Robert JACKSON	Chairman of the Directors of UK Medical Royal Colleges Royal College of Physicians of Royal College of Physicians of Royal College of Psychiatrists

ASSOCIATE MEMBERS

CYPRUS	Dr Nicolas CHRISTODOULOU	Cyprus Medical Association
CZECH REPUBLIC	Dr David RATH Dr Jan MACHAC	Czech Medical Chamber Czech Medical Chamber
HUNGARY	Dr Zoltan MAGYARI	MOTESZ

	Pr K. NEKAM	MOTESZ
SLOVAKIA	Pr Rastislav DZURIK Pr Andrej CERNAK	Slovak Medical Association Slovak
Medical Association		

Working Group Long Distance Learning
Dr Gilbert FAURE (Medical Biopathology)
Dr J. Hajo VAN BOCKEL (Vascular Surgery)

UEMS Specialist Sections

Dr Günter ABT (Orthopaedics)
Dr Jan P. AMLIE (Cardiology)
Dr Angelika BISCHOF-DELALOYE (Nuclear Medicine)
Dr Finn Trunk BLACK (Infectious Diseases)
Dr Eduard CABERNARD (Ophthalmology)
Dr Robert DE BEULE (Allergology and Clinical Immunology)
Pr Alain DELARQUE (Physical Medicine and Rehabilitation)
Pr Harald GOLLNICK (Dermato-Venereology)
Dr Toni LERUT (Cardio-Thoracic Surgery)
Dr Daniela MARCHETTI (Medical Biopathology)
Dr Maurice MOMMAERTS (Oro-Maxillo-Facial Surgery & Stomatology)
Dr Dimitrios PANOUSSOPOULOS (Surgery)
Pr Peter PATTYNAMA (Radiology)
Pr Jos SCHOENAERS (Oro-Maxillo-Facial Surgery)
Dr Robin STEVENSON (Pneumology)

European Scientific Societies

Pr Lino GONCALVES (European Board for Accreditation in Cardiology, EBAC)
Dr Joanna ORTOLI (European Board for Accreditation in Cardiology, EBAC)
Mrs Kathleen VANDENDAEL (Federation of European Cancer Societies, FECS)
Dr David VODUSEK (European Federation of Neurological Societies, EFNS)

Observers

Dr Dennis WENTZ (American Medical Association, AMA)

Management Council representatives

Dr Hannu HALILA (President)
Dr Bernard MAILLET (Secretary-General)
Dr Leonard HARVEY (Liaison Officer)
Dr Giorgio BERCHICCI (Vice-President)

Bénédicte REYCHLER (Managing Director)
Nathalie PAULUS (Secretary)