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EACCME®
European Accreditation Council for Continuing Medical Education

Annual Report 2002

1. Introduction, background EACCME:

The EACCME was established by the Management Council of the UEMS in its October 1999 meeting in Vienna and started operation in January 2000.
The purpose of the UEMS is the harmonization and improvement of the quality of specialist medical care in Europe.
In the field of Continuing Medical Education (CME) and Continuing Professional Development (CPD) the EACCME will serve this purpose by insuring accessibility to quality CME activities and securing European exchange of CME credits for the medical specialists in Europe.

2. Principles EACCME:

The EACCME has been set up as an UEMS institution and is governed by the UEMS Management Council, which is constituted by the representative professional specialist associations in the member countries of the European Union and associated countries. It is managed by the executive committee of the UEMS and has its offices within the office of the UEMS in Brussels. Partners in the operation of the EACCME are the national professional CME authorities and the professional specialist organizations and societies in Europe.

The practical instrument to improve the quality of CME in Europe will be the facilitation of transfer of CME credits obtained by individual specialists in CME activities that meet common quality requirements:
- Between European countries
- Between different specialties
- In case of migration of a specialist within Europe
- Between the European credit system and comparable systems outside Europe.

In order to make exchange of credits possible the "Hour of CME" equating to 1 credit will be used for the international awarding of CME credits. National systems should also use this unit or establish a fixed exchange rate with this unit.

The EACCME will not provide accreditation of CME activities directly, but it will connect the existing and emerging accreditation systems in Europe and act as a clearing-house for

accreditation of CME and credits in Europe. As such it does not supersede the national authority on accreditation of CME, nor does it create another layer of bureaucracy.

The UEMS will be committed to further evolvement of the procedures of the EACCME in cooperation with its members and its partners, the national professional CME authorities and professional specialist organizations and societies in Europe.

3. EACCME developments:

- Operation:

The start of operation in 2000 was slow which provided the opportunity to address the teething troubles of the procedures in a stage in which obtaining of credits by most of our colleagues in the field was not indispensable yet. This is rapidly changing and there has been a considerable increase of interest in Europe.

The activities of the EACCME picked up during the year 2002 substantially. Mandatory CME is increasing in the European countries due to national legislation or professional regulations and doctors are needing CME credits more and more in order to be able to continue practising.

- The UEMS Advisory Council for CME:

The UEMS Advisory Council, the steering body of the EACCME, links the accrediting bodies participating in the EACCME. Partners in the Advisory Council are the accrediting bodies, national and European, active in the field of CME. Associates in the EACCME are the UEMS Specialist Sections/Boards. As institutions of the UEMS they provide the EACCME with expert knowledge in their fields.

The Council convened in Brussels on 23 November 2002. In this meeting delegates of the National Authorities on Continuing Medical Education of the member states met with the UEMS Executive Committee. The meeting was attended by Dr D.K.Wentz, Director of the CME/CPD Department of the AMA (American Medical Association). The report of the meeting is published on the UEMS/EACCME website.

- EACCME Working Group 2002:

In the previous meeting in November 2001 it was decided to establish a Working Group with participation of various organisations represented in the EACCME to study pending issues.

The Working Group produced a background paper, which was discussed in the Working Group meeting in Brussels on 6 July 2002. The recommendations of the Working Group were forwarded to the UEMS Management Council meeting in October 2002 (Document D 0250 rev1).

*** Accreditation of distance learning programmes. Recommendation:**

"The UEMS Advisory Council on CME recommends to Management Council that expert advice is necessary in the field of internet-based CME and asks the EACCME to convene a group of individuals from the medical profession with both professional and technical expertise in the field of internet-based CME to report to Management Council."

This recommendation was approved.

*** Accreditation of certain providers for a period of a certain number of years.**

Draft Recommendation:

"The UEMS Advisory Council on CME recommends to Management Council that EACCME award accreditation, as a pilot project, in a limited number of instances:

* *for xx year(s) to xx professional organisers of CME activities, and to recognize their accreditation*

* *for xx year(s) of xx professional European accreditation bodies and to recognize their accreditation.*

The EACCME is required to report the experiences during the year 2003 in the annual report concerning that year."

Management Council did not approve this recommendation. The point will be reviewed.

* **CPD, Continuing Professional Development, incorporation into the EACCME (see D 0120, Basel Declaration). Recommendation:**

"The UEMS Advisory Council on CME recommends Management Council not take steps to incorporate CPD into the EACCME process because CPD is currently a national activity. Management Council asks its Working Group on CME/CPD to look into the matter of European accreditation of CPD and advice accordingly."

This point was referred to the UEMS CME/CPD Working Group accordingly.

4. The EACCME and General Practice / Family Medicine:

Concerning the European dimension of CME in general practice / family medicine there have been several contacts with the executive of the UEMO (European Union of General Practitioners), both in 2002 and before. Several European National CME Authorities are worrying about the lack of a European clearing system of CME credits in these disciplines like the one the UEMS has established in the EACCME for specialist medicine in its remit. The UEMO has been urged repeatedly to take action in this matter, but finally the UEMO decided to stay away from a European structure of CME in general practice / family medicine.

The EACCME has been receiving request for accreditation of CME activities in general practice / family medicine. So far the EACCME has rejected requests for accreditation in these disciplines on the ground that these disciplines are in the remit of the UEMO. It will be difficult to maintain this policy in the future.

5. The EACCME and the American Medical Association:

The EACCME and the AMA are recognising each others CME credits since 2000. Negotiations to extend this arrangement were conducted by the Secretary-General in April and June 2002. An agreement to extend this arrangement till 2006 was reached and approved by the AMA Council of Education in June 2002 and by the UEMS Management Council in October 2002 (see D 0234).

Concerning the quality issue of CME, contacts with the AMA and the ACCME (the American Accreditation Council for CME) have been laid. The ultimate goal is to establish a joint set of quality requirements for CME as an extension of the present UEMS document D 9908. Both the AMA and the ACCME have recent policy documents on the issue of quality. There are also the Basel Declaration of the UEMS in 2001 (D 0120) and the draft WFME (World Federation of Medical Education) 2002 document on CME/CPD.

6. Points of attention in practical operation:

- **Expanding involvement of governments**:
  When Ministries of Health are becoming involved in CME directly, the profession in those countries has to further the European dimension of CME with the Ministries. It is in the interest of both the national medical associations and their individual members. This is particularly valid for Italy, where in 2002 legal mandatory CME was introduced

run by the Ministry of Health. Consultations between the profession and the Ministry of Health are taking place already.

- **Regional autonomy / coherence national policy**:
  In countries with regional authority in CME matters, unification of procedures and some kind of national umbrella structure is necessary to make European exchange possible. Great progress on this issue has been made in Germany in 2002.

- **Coherence policy National Professional Societies / Medical Chambers and the National Medical Associations:**
  Cooperation between separate national professional institutions is necessary to reach compliance with European medical structures. Throughout Europe this is being recognized by the profession and policies are converging.

- **Function of the European Boards / European Professional Societies:**
  The EACCME needs professional organisations capable of quality control of CME activities. The UEMS Specialist Sections / European Boards are the principal institutions on which the EACCME relies, but there is no coverage of the whole field. This means that in many instances ad hoc solutions have to be found.

- **Professional assessment of CME activities**:
  Problem here sometimes is that no (Professional) Authority seems to be capable to determine the number of hours of CME credit that can be awarded to a specific activity. This is especially the case in countries where CME is completely voluntary. However, determining the number of Hours of CME Credit is not within the remit of the EACCME.

- **Fitting in of European specialty based accreditation systems:**
  Compliance with the EACCME system has to be developed further.

- **Transfer of credits in the case of migration:**
  In the case of migration to countries with a mandatory system transfer of credits is not giving problems presently, but with increasing mandatory CME in European countries this point has to be watched carefully.

- **Hour of CME Credit:**
  A universal unit of CME credits is necessary. This is the "Hour of CME Credit". When other units are being used, a fixed exchange rate is necessary. In the past this has been a problem in some countries, but most of the problems have been solved presently.

- **Funding of CME/CPD:**
  Funding of CME is a problem in every country. Continuing education for all medical personnel and its funding has to be recognized as an essential part of state-of-the-art health care and should have an ear-marked source of funding. Ultimately it has to be an element in the fees / insurance premiums / taxes patients pay for health care. In the November 2002 meeting it was proposed to organize a European conference on this issue.

- **Approval by national CME Authorities:**
  National CME Authorities have to be approached in every case. This is not going smoothly. Sometimes responses are slow in coming in and on national level the requests seem to generate confusion from time to time. The Management Council has stated very clearly that all applications have to go by way of the national authorities, but this means that the national regulatory bodies should facilitate this process in their own countries as much as possible.

In the previous EACCME meeting November 2001 it was decided that national authorities should notify the Brussels office about their judgement within 3 weeks after reception of the request with underlying documents from the EACCME. Failing this deadline, the EACCME would be authorized to award European accreditation without this information. In the present year the EACCME has needed to use this provision not infrequently.

- **Recognition of EACCME credits:**
  Adequate response by the national CME Authorities is in their own interest. There is considerable pressure from international societies to bypass the national authorities in obtaining European accreditation. This will undermine the position of the national regulatory bodies and will ultimately be harmful for the European structure of CME as a whole. A firm commitment by the national CME regulating bodies is necessary. The national CME authorities have been asked to confirm this in writing (see document D 0231).

- **Late arrival of applications for EACCME accreditation:**
  Here also deadline is necessary. A deadline of 3 months is proposed, also to be used with caution. Presently the requests are often coming in on much shorter notice, not infrequently after the event has taken place. It is necessary to adhere to a reasonable period. Only then the organizer can use the EACCME accreditation to attract more participants from abroad, which is an important effect of European accreditation.

- **Feed-back and Evaluation:**
  Proper quality policy, evaluation and feed-back to the EACCME are essential elements in quality management by organizers of CME, as stated in the quality document D 9908. Proper feed-back to the EACCME will be enforced more strictly in the future.

- **Purely national meetings:**
  In some instances European accreditation is being asked for CME activities that are clearly aimed at doctors in one country only. In those cases European accreditation does not make sense and should not be requested.

7. EACCME activities:

European accreditation was awarded by the EACCME in 2002 in 198 cases. The total number of applications has been somewhat higher due to applications for activities taking place a very short time before or even after the activity. In these cases EACCME accreditation hardly makes sense. There were also applications clearly intended for colleagues in the same country, in which case European accreditation does not make sense. In these circumstances the providers were contacted.

There are vast differences in the way applications are presented. Usually the full programme was presented together with the application. This is important, for the EACCME needs those documents in order to be able to apply for national approval and for quality assessment by a professional organisation.

In many cases the organizer of the activity already had documentation of these approvals at his disposal, in which case the procedure for European accreditation is easy and quick. In other cases much research was necessary, requiring much time.
Streamlining of the procedures is on the agenda for the next year.

8. Finances:

In the first half year 2000 the UEMS has paid the expenses of the EACCME, but starting July 2000 providers have been charged 100 euro for each European accreditation. This is a provisional amount. A sliding scale depending on the size of the activity will be used in the future. Income in 2002 has covered the expenses, but only just. The EACCME is self-funding and can be separated from the UEMS budget completely. The main expenses in 2000-2002 have been for meetings and travelling. But activity is picking up and investments in personnel, space and equipment have to be made shortly.

References:

- Bulletin EACCME October 2002
- D 0120, Basel Declaration on Continuing Medical Education / Continuing Professional Development
- D 0217, procedure document
- D 0231, letter to national bodies, 30 May 2002
- D 0234, protocol agreement with AMA
- D 0250 rev1, report Working Group EACCME
- D 0305, Report EACCME meeting 23 November 2002, Brussels
- D 9908, Criteria for international accreditation of CME
- D 0204, EACCME, annual report 2001.

These documents and more information is available on the UEMS Website www.uems.be (and also on www.eaccme.be), page EACCME and in the lists of numbered documents per year.

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ANNEX:

Overview CME activities with EACCME® accreditation in 2002:

In 2002 198 EACCME accreditations were awarded.
Geographical distribution:

Austria	10	Italy	66
Belgium	6	Luxembourg	1
Cyprus	1	Netherlands	5
Czech Republic	6	Norway	7
Denmark	1	Poland	1
Finland	1	Portugal	6
France	13	Spain	9
Germany	16	Sweden	3
Greece	5	Switzerland	24
Hungary	3	Turkey	2
Iceland	1	United Kingdom	9
Ireland	2		