EUROPEAN CME/CPD

Development and Structure in the Member States

Introduction

A major concern of the UEMS is the structure and facilitation of accreditation of CME/CPD activities with the awarding of appropriate credits (hours) to individual medical specialists throughout Europe. The UEMS established the European Accreditation Council for CME (EACCME©) in order to give Europe a co-ordinated system to facilitate such activity, without encroaching on the responsibility of national organisations where they exist. Requests for recognition increase exponentially. Consequently, the development of national structures needs to be carefully followed. The following document expands and updates, and should be read with reference to earlier reviews, in order to appreciate the rapid change in both attitudes and requirements in different Member States. However, the need for a formal record and recognition of a specialist's commitment to the maintenance of knowledge, skills and expertise continues to develop as a requirement in most Member States.

Where there has been no new information this year, then the last date is shown (in brackets)

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Austria (2005)

There are no new changes with the system based on the Medical Law of 2001 which made participation in CME/CPD mandatory (maintenance of skills and knowledge) following what had been a totally voluntary system established by the Medical Chamber (Österreichische
Ärztekammer) in 1995. The legal responsibility resides with the Austrian Medical Chamber who transferred the actual implementation to the Academy of Physicians (Österreichische Akademie der Ärzte, www.arztakademie.at), its educational arm.

The CME programme of this body (DFP, Diplom-Fortbildungs-Programm, approved December 2001) awards a certificate over a 3-year cycle. In each cycle 150 points (equivalent to hours of CME-credit) have to be obtained. Of these, a minimum of 120 points in the specific specialty in related certified CME [this may be divided into 1/3s - CME events (congresses etc.), peer review (quality assurance groups) and literature studies or on-line distance learning if associated with a successful exam]. A further maximum of 30 points can be obtained in freely chosen CME. Participation is the programme is still essentially voluntary. A high compliance has been achieved and a link with the legal requirements might be established in the future.

In the DFP programme, providers are recognised as certified CME providers following a specified procedure.

“DFP-online Courses” were approved and commenced in January 2003. Participation in certified interactive online internet-based CME activities are awarded specialty-related points. Certification of these courses follows professional assessment by a certified CME provider and by an expert in technical and didactical aspects of internet-based CME programmes.

The interactive website www.arztakademie.at provides extensive information to participants and is also used as monitoring device as well.

The programme covers medical and dental specialists, general practitioners and dental doctors.

There is mutual recognition of activities between the Lander.

There is high participation by the profession.

**Belgium (2005 - no new changes)**

CME/CPD is regulated by an organization within the State Insurance System (INAMI / RIZIV) and hence, is monitored by the profession, the universities and scientific organizations and the (mostly politically linked) insurance organizations.

The system was set up in 1994 and is composed of:

- a **Steering Group** for accreditation, with representatives of the three above-mentioned groups, subdivisions for GP’s and for specialists and a number of subgroups, among which is a Commission of Appeal.
Joint Committees (Paritair Comité - Comité Paritaire) for GP’s and for every specialty, composed of doctors representing the profession, the universities and scientific organisations, with the exclusion of representatives of the insurance organisations. Each Joint Committee evaluates the proposed CME/CPD activities and assigns quotas of credits to these activities.

administration provided by the national system,

Whilst the system is voluntary, registration and re-registration is enforced by the Insurance companies by means of incentives: accredited doctors can ask for slightly higher fees (4.5%) and receive a yearly premium of around 490 Euro.

The number of credits required amounts to 200 per year (1 hour equivalent to 5 or 10 credit-points), of which 3 hours must be Ethics, and 4 hours in group peer review.

Complementary to CME/CPD, a peer-review has been set up. Local evaluation groups of around 20-25 doctors meet four times a year and discuss results, costs, and guidelines for their practice. Participation in these groups is compulsory for accreditation.

There are no sanctions besides exclusion of accreditation, there is no recertification. Accredited doctors amount to approximately 80% of all practitioners.

Cyprus – Whole Island (2005)

The system in Cyprus is a voluntary one organised by the Cyprus Medical Association in conjunction with the National Scientific Societies. The system was commenced on the 1st January 2002 and the participation of doctors is high. it is mandatory from 1st January 2005 under a special law although the system continues to be run by the Cyprus Medical Association.

Computerised system with Registration and documentation of CME activities provided.

The unit of activity is the credit/hour. Each doctor has to collect 150 credit points within 3 years from which 50% must come from activities of his/her own specialty. Every year the collected credits must be submitted through the national scientific societies to the CME Committee of the Cyprus Medical Association (CMA). All participating doctors have the right to be informed about those credited points recognized by the Committee for the last year.

At the end of the 3rd year a certificate of successful participation in the Cyprus CME program is given to those doctors who will have collected 150 credits. The validity of this certificate is for the next 3 years from its date of issue.

The CME Committee of CMA grants credit points for each scientific event organized in Cyprus. It also recognizes the credit points given from other National Bodies of Europe/USA/Canada. If a Cypriot doctor submits a certificate of participation in an official congress abroad without an indication of the number of recognized CME credits, then the
Cyprus National Committee considers the duration and standard of the scientific program and grants appropriate points.

There is no specific funding although the Ministry does support some large events.

There is a contract with EACCME.

**Czech Republic (2005)**

CME/CPD is *mandatory* by the law establishing the Medical Chamber (to which it is compulsory to belong) as the National Accreditation Authority. Under a new Act of 2004, Postgraduate Education & CME also formally established as mandatory. There will be no sanctions for the first 6 years.

83 specialties are now recognised

CME/CPD is offered by the Chamber, the Specialist Societies, Universities and the Postgraduate Medical School.

There is a credit system over 5 years with live activity preferred but also distance-learning allowed and accepted (e.g. tests in magazines).

Re-certification is regarded as dangerous and bureaucratic.

**Denmark (2005)**

No changes. The system in Denmark remains a *voluntary* one monitored by the Danish Medical Association in conjunction with the National Scientific Societies. There are no plans for re-certification.

In line with the principles laid down in a revised postgraduate specialist training, continuing education is defined as a broad range of roles (e.g. medical expert, communicator, leader and manager, academic) covering the different functions of a specialist doctor.

In a joint policy paper (Spring 2002), the DMA re-affirmed its belief that only a voluntary system safeguarded the doctor’s independence with a planned programme based on need with efficient use of resources for CME/CPD. In addition to medical expertise, many other competencies are encouraged. It is recommended that CME/CPD occurs within a structured and planned process. The starting point is the identification of the doctor’s individual needs seen in relation to broader needs, followed up by planning and completion of relevant activities, implementation in practice, evaluation and finally registration of the educational activity.

Registration and documentation of CME/CPD activities are provided. It is personal, planned and confidential to the individual doctor. Registration is by the Internet (used by 2/3rd of
GPs) and only she/he has access to it. The system is designed to give the individual doctor the possibility to compare her/his own CME/CPD profile with the average of peer colleagues and to supply the DMA and the Scientific Societies with statistics of the level of CME/CPD participation. The unit of activity is the credit/hour.

Currently, 24 out of 40 Societies are participating in the system. GPs were the first to start and now 30% of them are involved. Whilst there is no resistance in principle, there are no incentives and most cite a lack of time and knowledge of the system. However, overall, it is known that the majority of doctors, that is 96%, participate in some sort of formal CME activities, e.g. courses, congresses and meetings, most of them for more than six days a year.

Financing and time are still barriers to CME/CPD. The doctors organisations have entered into agreements with the authorities, which is a positive basis to build on, but they are still insufficient. The GP’s and the specialist practitioners have established a CME fund, from which their participation in approved activities is partly financed.

A system for accreditation and evaluation of providers, based on sound principles, their working methods, good learning activities, mission statement and constant review, is not yet active.

There is a model to assist in Personal Development Plans.

As concrete activities, the DMA works for:

- The documentation and registration of CME.
- The furtherance of a collegial culture in which educational needs and planning are discussed between colleagues.
- The employment of IT technology.
- The development of an evaluation culture.
- The coverage of broad medical competencies in the courses offered.
- Public financing of CME activities.

**Finland (2005)**

No change – voluntary system with the majority participating but no exact figures.

**New legislation for CME/CPD for health professionals** has been enacted in 2004. The government has allocated 12 million euros for this education.

Health care professionals working in community hospitals or in primary care in community health centres should participate in CME/CPD educational activities for an average of 3-10 days a year depending on the length of training, professional and developmental needs at his/her workplace (FMA’s recommendation is that every doctor should spend 2 weeks each year in external CME/CPD activity).
The employer should pay the expenses – 20% by government.

CME/CPD must be based on proper planning and goals and it’s methods must be suitable for the professionals. Health care units must monitor their employees’ educational activities in addition to the professionals recording their own education. Feedback mechanisms must include evaluation of activities.

The National Evaluation Council for CME is now established with the involvement of the Specialist Societies and Universities. It essentially advises on principles and good practice. Quality criteria have been established for both courses and providers with a written booklet.

A national working group for CME/CPD of health care professionals in Finland has produces a report with recommendations.

A Personal Electronic Portfolio for CME activity is administered by the FMA giving an annual peer review but the number of participants is still small.
Recertification is not an issue.

**France (2004)**

A legal regulation has been introduced. Execution and assessment has not been implemented yet, but will be inevitable.

The system remains voluntary although there is a mandatory accreditation system for hospitals based on the specialty – this is under the control of the Ministry of Health.

**Germany (2005)**

CME (CPD) is now mandatory in all 16 Lander (States) with mutual recognition between their Chambers of Physicians.

Due to the federal system, the regional chambers of physicians are responsible for CME in Germany. Although there is a recommendation of the German Federal Medical Association concerning a harmonized structure for CME it is overseen by each of the 17 regional chambers. Therefore the nationwide mutual recognition of credits by each Regional Medical Chamber Authority is an essential point and effective.

There is open cooperation between the German Federal Medical Association and the many Medical Scientific Organisations and/or MDs’ Professional Boards along with their Academies.

The Senate for Medical Education of the German Federal Medical Association has issued updated guidelines for the accreditation of CME activities. This includes a catalogue of CME activities divided in 8 (eight) typical categories. These are: lectures and discussions,
congresses, workshops with active participation, interactive education (scientific print-media, CD, DVD, web), self-study, hospital activity and work as an author and/or lecturer.

Due to the increasing importance of long-distance learning / web-based training, the maximum score for interactive learning no longer has a maximum limit (cf the guidelines of the German Federal Medical Association, effective at the moment, of 60 points in each 3 years) - this is likely to be taken over by the different Medical Chambers of the different States in the near future.

The basis for gaining a CME-Certificate, issued by the different Medical Chambers, is related to a maximum collecting period of three years with a minimum of 150 credits as well as of five years with a minimum of 250 credits; both approaches are also listed in the recommendation of the German Federal Medical Association.

Some statistical data (all numbers approx., as per 2004-12-31):
- overall 306.000 MDs practising,
- 133.000 ambulatory care,
- 146.000 hospital care,
- 10.000 different public services,
- 16.000 other.

MDs have usually to pay for their CME-activities by themselves, industrial sponsoring is restricted by certain rules of MDs’ Legal Code on the one hand and ethical codes of different branches of pharmaceutical and medical-technical industry on the other hand, if applicable.

The Social Security Code V, effective from the 1st of January 2004, makes within its § 95d CME mandatory for MDs within the National Association of Statutory Health Insurance Physicians (KBV) and further strongly recommends CME for MDs in hospitals (“structure of the quality including the CME-proofs of M.D.-specialists”) laid down in § 137 of the mentioned Social Security Code V.

There is an obligatory surveillance by the National Association of Statutory Health Insurance Physicians (KBV). The CME-proof is to be shown first after a five years period (from the 1st of July 2004 until the 30th of June 2009).
This regulation applies for all MDs within the ambulatory care of the National Association of Statutory Health Insurance Physicians (KBV) (individually contracted, entitled or employed at medical centres).

Consequences, if CME-proof is incomplete or lacking:
- first quarter of the year after five years: 10% cut off from fees
- fifth quarter of the year after five years: 25% cut off from fees
Reduction of fees stops at the end of that quarter of the year, after the completed CME-proof is shown officially.

- two years after the five years period: withdrawal of accreditation/contract with loss of licence to practice.

It is laid down in § 95 d of the Social Security Code V, that the contents for a CME-certification are to be determined via the Medical Chambers, i.e. the German Federal Medical Association. The Medical Chambers try, along with the Scientific Medical Associations and Medical Professional Boards, to help the individual MD to fulfil his/her needs of coping with the legal requirements.

E-learning - some of the Medical Chambers are considering an intensified offer of web-based CPD (e.g. - the Bavarian Medical Chamber is running an open co-operation with the Royal College of Physicians and Surgeons of Canada - www.mainport.org; the Professional Board of Surgeons is offering a special, multi-lingual IT CPD-platform).

Via the Medical Chambers, a systematic approach is being realized in 2005 for MDs to have an individual on-line-credit-account to serve at least all 130.000 MDs in legal need of an appropriate CME-proof – the system is similar to that of the German Society of Dermatology which is already running one for their approximately 5000 members.

There is a central server-technology being applied in October 2005 to allocate the electronically registered CME-credits of a MD from any congress site throughout Germany to the individual on-line-credit-account with the Medical Chamber responsible for the individual MD.

N.B. Whilst from the European point of view there is still no sole national organisation for CME/CPD in Germany, CME-Credits given by EACCME are usually fully accepted by the Medical Chambers of the States within Germany along with the German Federal Medical Association.

**Greece (2005)**

No new changes - still regarded as an ethical obligation i.e. voluntary. No re-certification.

CME/CPD activities may be offered by Universities, Scientific Societies, Hospitals or even individual doctors. All work independently with no co-ordination, monitoring or evaluation of quality at the National level.

There is an on-going discussion between the Health Ministry, the Panhellenic Medical Association and the Scientific Societies on regulation and financing of CME/CPD.

Funding remains the major problem.
Hungary (2005)

Hungary has a population of 10 million. Physicians (some 37,000) must be registered with the Hungarian Medical Chamber, which is legally responsible for issuing a Licence to Practice. All licences have to be renewed by March 2005.

A Legal Regulation for CME making it mandatory was issued in 1999, updated and modified in 2003.

The Medical Chamber is the National Accreditation Authority and has organised a body, the Committee for Quality Control of CME, for awarding points through the Scientific Societies.

The requirement is for 250 credit-points to be collected over 5 years. Of the 50 points per year, 20 may be given for practicing medicine with organised and peer-reviewed programmes (1500 accredited) available for the remaining 30 points. Individual scientific activities also encouraged.

All physicians are recommended to register with one of the 4 Universities to record credits earned.

A formal system and organisation for CME/CPD for GPs is now working well in all 4 Medical Schools under the control of a Supervisory Steering Committee, to which doctors pay to be registered and is connected to industry. There are 6000 GPs with a requirement for 250 points in 5 years. Failure to comply will result in having to undertake a special examination before a Commission. The first cycle will be completed in 2004 and a formal review will then occur.

Failure to comply results in restriction on independent work, with practice under supervision.

Iceland (2005)

A formal accreditation system is expected within the next 12 months.

Currently consists of 2 weeks CME abroad at the expense of the employer.

It is organised by the Icelandic Medical Association and supported by the University of Iceland.

It is an entirely voluntary system and no legislation is planned.
Ireland (2005)

Still no change to the Medical Practitioners Act (still being rewritten). It is this Act that gives each doctor his/her licence to practice medicine. If CME/CPD is to become compulsory, then this Act must be changed to reflect it. It is likely that mandatory CME /CPD will be required for all physicians at some time over the next two years. Some mechanism is likely to be introduced, which will require that every doctor in independent practice will be required to demonstrate participation in ongoing educational activities for the dual purpose of reassuring both the general public and the regulatory body of maintenance of ones’ competence to continue as a medical practitioner.

A new Minister of Health supports self-regulation through >50% lay people on the Irish Medical Council (Regulatory Authority). It has circulated documents to all doctors regarding doctors’ obligations to the general public, the medical profession and themselves in the area of ongoing assurance of medical competence. It identified three main areas - CME/CPD, Clinical Audit and Peer Review – in which this competence to practice could be assured. A booklet proposes that providers of CME/CPD in the future provide CME/CPD under the headings:

- CME/CPD 60%
- Audit 20%
- Peer Review 20%

The Medical Council has appointed a Director of Competence Assurance.

CME / CPD forms part of the Medical Council's Competence Assurance System. Competence Assurance has applied to all doctors since 2003.

The structure is divided into three levels.

- Level One consists of CME / CPD and Quality Assurance for all doctors.
- Level Two will focus training and help for groups of doctors perceived to be 'at risk'. These might be doctors over 50.
- Level Three will focus on individuals whose practice of medicine makes them a danger to their patients. It will be a remedial process.

For CME there will be a credit system:

- 250 points must be earned over 5 years.
- 1 credit per 1 hour of educational activity
- There will be 4 domains:
  - Internal CME/CPD - based in hospitals or general practices. Minimum 10 credits per year
External CME/CPD - regional, national, international. Minimum 20 credits per year
Personal Learning (independent study). Maximum of 10 credits per year.
Research and Supervision (postgraduate). Maximum of 20 credits per year.

Clinical Audit, Peer Review, and Performance Assessment will be elements in the Quality Assurance System. These will be phased in from 2005 or shortly thereafter. Target dates have been set so that participation in approved CME activities will be formally documented for all doctors by the end of 2004. The structures supporting participation in clinical audit and peer review are still being developed in consultation with the profession with a view to their formal introduction by the end of 2005. Pilot projects have been started but funding is still a problem.

The Council has devolved responsibility for CME/CPD to three separate bodies – The Irish College of General Practitioners (ICGP) for GP's, The Royal College of Physicians of Ireland (RCPI) for physicians and The Royal College of Surgeons in Ireland (RCSI) for the surgically related specialists. There is close consultation between them.

The Government has also set up a new Irish Health Services Accreditation Board initially looking at hospitals but also individual self-assessment and peer-review.

CME, though voluntary, is already a well-established reality in most specialties and for most doctors.

**General Practice.** Contract-holding general practitioners in the Social Security System (G.M.S.) are entitled to claim 10 days paid study leave per year – only 60% claim. Most CME remains an out-of-hours activity without protected time.

The most popular educational activity is attendance at small-group learning meetings with 70% of GPs attending such meetings per year. The provider is a GP CME Tutor based in each faculty area. Each Tutor organises 4-7 small-group meetings per month, which take place monthly throughout the academic year from September to May (the following year). The group themselves decide their specific education needs. This common approach meets the needs of the majority. The aims / objectives, method and evaluation of meetings are the responsibility of the Tutor. There are 30 tutors who report monthly to the National Director of CME Tutors are unable to provide individual programmes based on personal learning plans.

The National CME Director organises 3 residential workshops per annum for the tutors. The National Director and Tutors have a commitment to continuous QA (Quality Assurance) and QI (Quality Improvement). 50% of doctors in established General Practice attend CME activities in any one month. There is also a menu of educational activities s/he can choose from to meet each doctors needs including Distance Learning Programmes in Therapeutics, Women's Health...
and Palliative Care. There are also Skills Courses, Study Days and formal Lectures. Reading and Internet activity are difficult to quantify.

In General Practice there is very little dependence on the pharmaceutical industry. If a meeting is sponsored, it is on the basis that GPs have control of the content.

The Irish College of General Practitioners (I.C.G.P) is preparing for the probable change in the Medical Practitioners Act, by looking at a system whereby:

- An individual can “log on” / register his/her CME activity centrally (voluntary activity).
- Devise a “weighted” system of CME Credits, with a view to meeting the requirements of the Medical Council (regulatory Authority) for a split of 60% CME, 20% Audit and 20% Peer Review.
- Remedial Education Programmes need to be devised and provided, probably by a separate agency. Funding source not decided yet.

**Hospital-based Specialists.** Participation in CME remains a voluntary exercise but this does not reduce the interest and enthusiasm for ongoing education and skill maintenance in hospital-based specialists in Ireland.

Specialists working in acute public hospitals have employment contracts and are entitled, on average, to 10 working days paid leave + a financial grant of approximately 1,270 Euro each year to support their participation in CME activities.

Conversely, doctors working in exclusive private practice – be it in a hospital or general practice setting - have to fund their own CME.

Many specialist training bodies, for example surgeons, radiologists, psychiatrists and pathologists to mention but four large groupings, have quite sophisticated CME Programmes, with 60-70% participation, already functioning and well established. The RCSI report that, for surgeons, a 70% participation rate has been noted. A confidential Internet site – will become mandatory in next few years.

Whereas participation for physician specialists is also a reality, there is a wide variation in participation according to the specialty. Furthermore the administrative capture of the extent of each physician’s personal portfolio is not as well developed as in the other specialty groups referred to.

It has not been decided what action will be taken for non-compliance.

**Italy (2005)**

In 1999, the Italian Government passed an Act in Law making CME **mandatory** both in the National Health System and in Private Practice. A special National Committee of the Ministry of Public Health, chaired by the Minister of Health, is responsible for all relevant decisions. It
controls the criteria, contents, credits and providers. Regional Boards have also been nominated.

Registration and certification of credits is (probably) going to be assigned to Professional Boards.

All CME activities are placed by the providers on a dedicated web-site of the Ministry of Health stating objectives, etc. It charges between 250 – 750 € to accredit each event.

The Italian Ministry of Health started a mandatory system for all healthcare professionals from April 2002.

The system is complex with the CME Commission of the Health Ministry implementing the following framework:

- The system will award 10 points for 2002, 20 in 2003, and so on until 2006, when it will be up to 150 points/3 years on a par with other European CME structures.
- 90 days are required to register any activity.
- The healthcare professional has not the full choice of his/her ECM: part of it must be obtained according to the National/Regional health priorities.
- 60% of all educational activity will be organised by local health authorities, and 40% by other providers, such as the Scientific Societies, Universities, etc. at national level.
- Credits and Education will embrace other professional health categories.
- Referees are supplied by the Societies, but it’s not clear how they will be involved.
- The European EACCME model has been studied, in order to eventually reach harmonisation with UEMS, with consideration of the organisation of international events by separate authorities such as CME-ICAP, as well as the umbrella of the Committee for Scientific Societies.

From 2004 there is planned:

a) Introduction of Long Distance Learning
b) Introduction of Accreditation of Providers (National and, possibly, Regional)
c) Introduction of other forms of "learning by doing" (formazione sul campo).

All healthcare workers, not only doctors, are to be involved (800,000).

Credits vary according to the type of educational activity with the maximum of 10 credits for a full day.

The system has the support of the Italian Medical Association although they have stressed the difficulties of implementation.

The Government has set up commissions to investigate:

a) Characteristics of providers, initially institutional with others later.
b) Economic support of CME/CPD

There are 330,000 doctors who can claim virtual credits on the Internet. Providers are required to register.

Quality Control Assessments are the biggest problem and not yet commenced either of providers or events.

Financing is solely by the Pharmaceutical Industry which therefore has a major effect.

Luxembourg (2005)

CME systems exist which are controlled by the profession and remain entirely voluntary. With no Medical School, postgraduate, like undergraduate training, has to be accomplished abroad.

Continuous Medical Education is considered a moral obligation for each practising physician towards his patients and society and this moral obligation is included in the national Code of Ethics.

CME is done on a voluntary basis, each physician is responsible for identifying his own needs and to attend local or across the border events to keep updated. Local events are organised by the national specialised societies, hospital departments and the national Society for Medical Sciences. The events usually consist in evening or half day events around a specific topic or case conferences. The local organisers are in charge of finding speakers and funding and often use sponsorship from industry on an unrestricted grant basis.

Most doctors will attend international congresses and conferences, go to courses but only a few will present or publish original research.

Government support for CME has so far been patchy and limited to courses on politically fashionable topics such as environmental medicine and pain management.

A project to set up, with government support, a body in charge of monitoring quality of CME and co-ordinating the timetable of events has so far not been achieved because of lack of political will. At present the allocation of CME points for events open to international attendance is done by the National Medical Association after recommendation of the specialist society.

Systematic monitoring of each doctor’s CME activity, combined with some kind of obligation, is not yet on the agenda in Luxembourg and will only be acceptable by the NMA if appropriate funding for CME activity of doctors is provided.

Malta (2005)

There is a voluntary system in place run by the profession. There is a high level of compliance but a problem with funding.
Netherlands (2005)

Within the framework of quality legislation in the area of health care, a 1993 law prescribed registration of all physicians, pharmacists, physiotherapists, health care psychologists, psychotherapists, dentists, midwives and nurses. This law became effective in 1998 (www.bigregister.nl also in English).

Registration and re-registration every 5 years is required for medical specialists, the first term being implemented in 2003. The implementation is supervised by the Ministry, but carried out by 3 Colleges/Registration Committees, one for the 28 clinical specialties, one for the specialties in general practice and one for “social medicine” (occupational medicine, insurance medicine and public health). These bodies operate within a legal framework. The requirements have been limited to the type and quantity of practice, although continuing education requirements will be effective in the future when there will be a mandatory requirement for 40 hours of CME yearly on average (over a 5 year period) for all medical specialists in the 3 groups. This agreement has been ratified by the Ministry of Health and is effective from January 1, 2005 onwards.

In 2002, the Royal Dutch Medical Association (KNMG) took the initiative to establish an umbrella structure for a system of unified accreditation of educational activities and mutual recognition of continuing education credits for all physicians. The professional societies in the 34 recognized specialties were brought together in the “Accreditatie Overleg” (Accreditation Consultation Body). In the meeting of this body in Utrecht in July 2004, representatives of all professional societies reached agreement to establish a harmonized system of accreditation of CME activities with mutual recognition of credits within the 3 groups of specialties. Use of a uniform application form and a uniform assessment procedure were introduced. The documents (also in English) are available on the website of the KMNG (www.knmg.nl) and the websites of the professional societies.

In the meeting of the Accreditation Consultation Body in Utrecht in April 2005 the representatives agreed to set up a joint fully digital system for accreditation of CME activities and registration of CME credits of individual doctors. This will be based on the voluntary (already operational) systems used by cardiologists, gynaecologists and general practitioners.

Accreditation will remain the responsibility of the separate professional societies. Establishment of a central national CME authority is not contemplated.

Presently the professional societies are participating separately in the process of European accreditation through the EACCME®.
Norway (2005)

Presently most medical specialists in Norway participate in some way in CME activities. Except for general practice, CME is voluntary.

For specialists in general practice (recognised since 1985), there is mandatory re-certification every 5 years with a financial incentive of approximately 20% of the fees when CME requirements are met – this economic incentive has proved very effective with 90% complying. It is, however, not necessary to be a specialist in general practice to work in general practice (which means that CME is not really mandatory).

Government has not decided on re-certification for specialists, but Parliament has expressed its view that a similar system for re-certification, as in general practice, should be considered also for the other specialties.

The Norwegian Medical Association has therefore decided to carry out a broader pilot study during 2004 in Gynaecology and in Pathology, according to the same principals but with better tools and better preparation.

The National Council for specialist education in Norway in Spring 2003 delivered a recommendation to The Ministry of Health for a more formalised and documented CME for medical specialists. It did not recommended a re-certification system, but recommended establishment of a CME system similar to the one carried out in the pilot study of the Norwegian Medical Association.

In brief, this means that each individual specialist plans his/her CME activities for the next year. The plan is discussed and acknowledged by a colleague and then accepted by the hospital department (the employer). The CME activities are carried out according to the plan and when the year is over the activities are evaluated by the same colleague who agreed the plan. All specialists report their CME activities and the evaluation to the head of department in the hospital, and the summary of all specialists’ CME activities are reported by the hospital department to the specialty committee in The Norwegian Medical Association. This will be a supplement to the written report which is mandatory for all hospital departments accredited to give specialist education. A similar system has been recommended for specialists in private practice. It seems as if The Ministry of Health will await the pilot study before deciding upon a national system for CME.

The financing of CME activities has also been an impediment.
Portugal (2003)

CME is entirely voluntary with no plans to make it mandatory.

In the Public Service, 15 days paid leave is allowed per year for CME activity after 10 years service.

There is also a dedicated TV channel free to doctors.

The Portuguese Medical Association organised a major Conference on CME in June 2000. Ministry is trying to limit the 15 days allowance.

Slovakia (2005)

A formal 5-year mandatory system has now commenced run by the Chamber, the Universities and the Scientific Societies.

Various organizations participate in CME/CPD in Slovakia: the Postgraduate Medical School is under the control of the Ministry of Health with an extended activity into in CME/CPD; the Slovak Medical Chamber and Slovak Medical Association (SMA) are probably the most important institutions for future development. Three Medical Faculties are involved in CME/CPD activity at the present time and have coordinated and unified the criteria of credits. These have been changed to be in agreement with the international credits on the basis of the UEMS EACCME.

CME/CPD is already done in a different way to other EU countries because of differences in postgraduate education. It is definitely accepted that EU education system will be adopted in the shortest possible time and all preliminary activities have been started.

As yet, no sanctions for non-compliance.

Slovenia (2005)

CME/CPD is mandatory by law since 1992 with the Medical Chamber of Slovenia responsible for its administration and with partial funding of authorisation by the Ministry. A new law applying to civil servants includes doctors as the only profession.

Licences are awarded/issued to physicians by the Medical Chamber of Slovenia (MCS) for a period of seven years; recertification is mandatory and possible by gathering at least 75 credit points through participation in accredited forms of postgraduate education (the criteria for 1 credit point is the same as in most of the EU countries and some of them are also approved through the system run by the EACCME® UEMS). The number of compulsory credit points to be collected during one licence renewal period appears relatively modest comparing with given /established European recommendations (on voluntary basis). At a time of conflicting views and
opinions regarding the relevance of collecting CME/CPD points, this is felt to be the best possible compromise between those in favour and those against mandatory recertification.

The authority to award the specific amount of credits points to individual scientific/professional meetings or other forms of CME/CPD is held by the MCS in cooperation with the Slovene Medical Society (and its many scientific/professional societies), the authorised representatives of which are reviewers/evaluators of the quality and accountability of registered CME/CPD education. In 2002, there were awarded credit points to 248 organisers of domestic professional meetings and 500 individual applicants. More detailed analysis of their 10 years experience with mandatory recertification in Slovenia could be presented at the next EACCME meeting if there will be the opportunity to give such a presentation.

Within a broad project, running under the title "Quality of Medical Practice", the MCS is collecting the data on various aspects of the quality of work of individual physicians, working both in public institutions and private medical practices, analysis of which will form the basis for QI processes planned in the future. In order to connect in some way the process of recertification and CPD, efforts are being made to find the appropriate way to award certain (important) amounts of credit points to those physicians actively participating in this process. Also the presentation of aggregate analysis of these data with the discussion on how to redefine CME/CPD activities in a more transparent way could be offered to the EACCME auditorium at its next meeting.

It is believed that formal CME/CPD is one of the few objective means of assessment of quality in health care. Attempts are being made to establish an Audit & Peer Review system with an advisory function but it is only possible to involve 2.5% of doctors each year.

CME providers are starting to be accredited by the Chamber in collaboration with the Scientific Societies.

**Spain (2005)**

By law, the 17 Regional Autonomous Authorities are responsible for Continual Health Education and not the Ministry of Health. Each Regional Autonomous Authority has either a CME Commission or has surrogated it in a Central Commission.

There is a National Commission for Continuing Health Education, which is a Sub-Committee of the Inter-territorial Council (composed of the Ministry of Health; the Ministry of Education; and the 17 Autonomous Authorities).

The system is not mandatory and no Spanish Committee may grant authorisation to providers but accreditation only of single activities.
The Instituto de Formación Médica Colegial (IFMC) of the Organización Médica Colegial (which holds the registration of all doctors) has developed a structure for CME, execution and assessment has now been implemented.

The Scientific Societies are anxious to develop the role of providers.

The Spanish Medical Association (Consejo General) has also developed its own system which is active at the present time. They have signed a mutual agreement for recognition of credits with UEMS EACCME.

There would appear to be still areas of disagreement between the various participants.

**Sweden (2005)**

The system is still entirely voluntary and there is no intention to introduce re-certification.

Some societies have their own systems but the issue is regarded as essentially an employer-employee matter.

The main problem is the lack of resources for CME/CPD due to budgetary restraints. Most of the doctors (90%) in Sweden are employed under the State Healthcare System, and have to negotiate their participation in CME/CPD events with their employer. An imbalance exists between need and funding.

The Swedish Medical Association has produced a document on CME/CPD stressing the importance of proper documentation and transparency and advocating the use of a log-book, rather than the use of credit-points, which some Specialist Societies award.

The “Institute for Professional Development of Physicians – IPUS” (the recognised Authority for CME/CPD) has been established (2002) with the Swedish Medical Association, the Swedish Society of Medicine and the Federation of County Councils (the employers organisation) as co-founders. The Institute supports the healthcare's need for continuing professional development of physicians. Its main service is to improve the accessibility to quality assessed education. Staff have been recruited, and the first set of criteria for CME/CPD events has been established. The IPULS website, which publishes all approved CME/CPD events in Sweden, was launched in 2003.

**Switzerland (2004 - no new changes)**

CME is well structured and regulated. When CME requirements are not met, the specialist concerned can loose his membership of the Foederatio Medicorum Helvetiorum, which makes it very difficult to contract insurances and to practice.
Became mandatory in April 2002 and a diploma is being prepared. The system is being jointly managed by the Scientific Societies and Medical Association.

**United Kingdom (2005)**

CME has now almost disappeared as a concept in favour of the broader, more multidisciplinary and active CPD.

CPD is virtually mandatory but not legally so. There are 3 separate elements to the UK system:

a) The General Medical Council (the national medical regulatory body) has devolved the administration and monitoring of CME/CPD activities to the Royal Colleges, which are linked in the Academy of Medical Royal Colleges (Directors of CPD Committee). The Academy (through its Directors of CPD Committee) is looking at many, general CPD issues - including CPD involvement in re-training doctors for return to work, CPD and consultant career changes, on-line CPD, and CPD for those in private practice, in retirement, and in non-clinical positions (e.g. College Presidents).

b) The General Medical Council is introducing a revalidation system for all licenced practitioners in which CPD activity and their annual appraisal will be an important constituent. From 2005, every doctor will be subject to 5-yearly revalidation by the General Medical Council, the body that regulates the whole of Medicine in the UK. Five successful yearly appraisals will form part of the evidence required and the PDP’s within them will therefore be important. But the evidence will be much wider than this. Doctors are encouraged to keep a “revalidation folder” with documents supporting all aspects of work (including clinical work, teaching, research and publications), relationships with colleagues, the views of patients and carers, health and probity.

c) In every hospital, "clinical governance" has been introduced which is the responsibility of the hospital Chief Executive (a manager) and addresses the quality of Health Care provided to patients. The basis is that individual specialists are required to undergo “appraisal” on an annual basis in which their personal profile, including details of CPD activity is assessed. This should also reflect the needs of the employer (i.e. the hospital). Appraisal is a contractual obligation and being extended to non-consultant grades as well as trainees.

The relationship between CPD, appraisal, and revalidation is now becoming a little clearer.

CPD will be based on a yearly Personal Development Plan (PDP), drawn up for each doctor in a peer-group context (usually with the specialty Clinical Director). This is approved by the appropriate Royal College but not directed by it.
The doctor’s PDP will form one part of the evidence for the yearly appraisal of his/her work carried out by a manager within the employing authority. Appraisers have special training and may or may not be a doctor. This is part of clinical governance, which theoretically gives the doctor a chance to comment on the management in turn!

The views of patients and carers are becoming more and more important on appointments committees, in training, and in 360° Appraisal schemes.

The profession currently has 2 major concerns:
a) The results of a long and detailed government enquiry into a medical GP serial murderer (Shipman Inquiry), which may require changes to the GMC proposals on revalidation.
b) The advent of the Postgraduate Medical Education and Training Board, which will oversee medical training. Many of its principles are refreshing, including the need to see training as a continuous process from medical school to consultancy but it is not yet sure where CPD fits in.

While the profession, as a whole, fully accepts the rationale of formally recording CPD activity, there is considerable debate and concern at the direction and excessive regulation being imposed by Government and the threat of attempts to re-direct doctors’ careers.

Associate Members

Croatia (2005 - no new changes)

Until 1995, CME/CPD was voluntary.

Following the reforms, the Government established the Croatian Medical Chamber (CMC) to which all 13,000 physicians were obliged, by law, to become members in order to practice medicine. The Institute of Licensure and Re-licensure was established by them. Thus the Chamber also became the National Authority for CME/CPD.

Initially, all physicians with state examinations, already practicing medicine, were granted a license for independent practice. All these licenses were to be subject for re-licensure after 6 years so that re-certification has now started. The only condition which every physician has to fulfill is the collection of 120 points of CME/CPD (20 point each year). The manner of collection is regulated by the Croatian Medical Chamber’s book of regulations. So far only a small number of doctors have failed to comply with the requirements but they will have to undertake a formal exam early next year if they wish to continue to practice.

The CME/CPD activities accepted for the collection of points are:

- active and passive participation on national and international congresses,
- first grade and other courses of CME/CPD,
national and international seminars,
attendance to expert meetings,
obtaining a Master and/or PhD Degree
publications of articles in scientific medical journals, editing or writing a book or a chapter in a book,
activities towards public health awareness.

From all the 120 points needed to achieve a re-licensure, only half (60) can be from the same type of CME/CPD activities.

There are 121 Scientific Societies, which are 50-70 years old, and Sections of the Croatian Medical Association, with a high membership but not compulsory (75%).

CME/CPD is organised and provided by the Specialist Societies, the Sections of the CMA, the Academy of Medical Sciences of Croatia, the Universities and some Hospitals. The 4 Universities approve 20-25 first-degree courses per annum, which carry higher credit point numbers.

In 1995, a joint Commission was established between the Chamber and Association for continuous medical development in order to evaluate credits points for different courses and meetings. The CMA has been excluded since 2000. The CMA is now establishing a National Authority comprising all organisations involved in CME/CPD. It intends it to:

approve providers
administer credits
promote societies/sections to organise courses and meetings.

There is an increasing explosion of meetings, courses and congresses.

Romania (2003)

A special law of 1995 gave a specially founded organisation, the Romanian College of Physicians, the attributions of professional jurisdiction and supervision of CME/CPD, which includes the right to a licence to practice. It has jurisdiction over scientific activities and established mandatory CME in 1999 (2 years ago) with a requirement that each doctor must obtain 200 credits within a period of 5 years.

Providers are accredited with help of Scientific Societies and the Professional Organisations – rules include experience and no commercial links.

A scale of crediting has been established according to the difference between courses with and without a final evaluation as well as taking part in conferences and congresses.
Failure to obtain the 200 credits by a doctor can result in exclusion from membership of the College for 6 months or longer, which immediately leads to the removal of the right to practice medicine. This is viewed as the first step to re-licensing.

**Turkey (2003)**

CME/CPD is not mandatory but still voluntary in Turkey. Activities are widely provided by the medical schools, professional bodies, ministry of health, medical industry and foundations. The CME-Accreditation Council of the Turkish Medical Association has been accrediting meetings, conferences and workshops since 1994. Over the years, accredited CME-CPD activities have reached 10,000 hours of activities per year. This council has been trying to introduce standards, as well as encouraging providers and participants to organize and take part in these activities. Ethical standards have also been established for the providers and the participants by the Turkish Medical Association for CME/CPD.

**U.S.A (2005)**

Their is a provider-based system with some 2,600, who are the only accredited providers, which once given enables them to designate and award AMA PRA category 1 credits. Some are national entitlements (700) whilst others purely local (1900). Accreditation is only for US-based activities. For international recognition, then a separate specific application in advance is required.

There are 715,000 doctors with active licences to practice. In 40 States, the system is mandatory on all doctors and there has been a complete shift to the concept of CPD. Anxious to put the individual doctor back in charge and now moving to a concept of "maintenance of certification" by the 24 Specialty Boards – historically, an exam every 7 years but now aim for greater flexibility although there will still an exam some time in each 7-year period but now emphasis on an individual Portfolio which includes CME activity but goes much further..

The new Accreditation Council for Graduate Medical Education (ACGME) has laid down 6 competencies that all residents must achieve. They are:

- Communication skills;
- Clinical ability;
- Professionalism;
- Ethics;
- Knowledge of working in the Healthcare system;
- Ability to work in a team.

Currently working on 2 new issues:

- Performance-enhancing activities for quality assurance and good feedback
• Internet activities on an inter-active basis on point-of-need requirement (eg eSkolar which will give a clinical response in 8 seconds). Many enduring materials exist but there is comparatively little take-up.

Credits also obtained from LDL and peer-review activities in quality journals.

Generally, credits are given with more flexibility to the time involved depending on type of activity.

Also, a framework document has been established to ensure consistency between providers.

Global standards for CPD quality are being established with other continents.

Funding – much is from industry which accepts strict rules governing educational grants but there are continuing concerns. There is no question as to the independence of the provider.

Quality of Healthcare Provision – every hospital had to be regularly accredited on an extremely demanding investigation involving the quality of the staff. In turn, the admission rights of every individual doctor have to be renewed every 2 years when their maintenance of knowledge and skills is also assessed.

**European Societies**

1. **European Board for Accreditation in Cardiology (EBAC) (2005)**

   Had been established in Sept. 2001 by the Section of Cardiology supported by the European Society of Cardiology with 3 members from each body with a term of 2-4 years.

   It concentrates on quality control and facilitating of CME/CPD events. Registration is purely via the Internet with 3 independent evaluators (unpaid) following strict guidelines.

   160 events, 20 web-modules (for Long Distance Learning) and 2 CD-Roms have been approved to date.

   Wanting to move to approve providers.

   All requirements are based on EACCME® criteria and are very strict on commercial support.

   It has created its own website, which is updated regularly.

   Stresses that it is non-profit although fees are high.
2. **European Board and College of Obstetrics and Gynaecology (EBCOG) (2003)**

Has created a Standing Committee on CPD (SCCPD). Through the SCCPD, EBCOG aims to develop a mechanism for the recognition of activities leading to the awarding of CME points and to devise a European system of CPD, which incorporates existing CME programmes. It believes that it is now time for EBCOG to take steps towards CPD, which is more difficult to quantify and assess than CME. The SCCPD has proposed the implementation of a system of annual appraisal whereby the CPD programme would be organised a year in advance in order to help with the CPD appraisal.

3. **European Board for Accreditation in Pneumology (EBAP) (2005)**

Established in 2001 (along the same format as EBAC) by the UEMS Section of Pneumology supported by the European Respiratory Society, with 3 members from each body each with a term of 24 years. Its aim is to concentrate on quality control and facilitating of CME/CPD events. It does not approve providers, only events.

Since 2002, all requirements are based on EACCME criteria and are very strict regarding commercial support.

Although fully active for 12 months, is not that vigorous as yet.

It has concerns regarding relationships with the national Accreditation authorities.

The Board has established its own web-site, www.ebap.org, which is regularly updated.

4. **European Board of Urology (2003)**

EBU has an established Accreditation Committee, which processes applications for accreditation of CME/CPD activities at both a National, European and International level. Each application is assessed by members of the Committee (by mail/Email or at their meetings).

Credits are given according to the general rule of 1 credit per hour and in line with the general rules of EBU, documented in 'Continuing Medical Education and Continuing Professional Development', Alberto Matos Ferreira, version February 2003.

Regular evaluations of the events should be performed by either the national EBU delegates or members of the EBU Accreditation Committee.

The organiser is informed on the accreditation, the category and the EBU credits

EACCME is informed on the accreditation, the category and EBU credits

Credits are attributed to the activity and processed in the CME/CPD database, available on the Web. The Website also will include this activity as being EBU CME/CPD accredited.

In co-operation with the Vascular Societies there is support for the EACCME initiatives. The CME Committee of the Vascular Division of the UEMS has been encouraging the provision of a monitoring system for vascular CME in Europe for 3 years. Validation forms for accreditation are requested and delegate questionnaires on quality are required following the meeting.

European CME points are allocated to meetings providing the delegates and speakers come from a number of European countries (specifics are available on request).

There is a charge of 50 Euros per credit point.

6. **European Federation of Cancer Societies (FECS) (2005)**

FECS established the **Accreditation Council of Oncology in Europe (ACOE)** in 1999. ACOE is an independent multidisciplinary body under the umbrella of the Federation of European Cancer Societies (FECS). The Council is representative of the complete spectrum of oncology health carers (not only physicians) from all over Europe.

ACOE accredits international CME events in the field of oncology and works jointly with the EACCME for the recognition of CME credits in all European countries and in the United States.

As part of a three-year grant from the European Commission, under the Leonardo da Vinci Programme, FECS has conducted a survey amongst health professionals, which reveals that 96% of them believe that a system of mutual recognition of CME credits between European countries is needed. A quarter of the respondents from EU countries consider as a main weakness the fact that CME credits are not recognised in their country. A large majority (80%) are in favour of the accreditation of enduring materials.

ACOE strongly supports the EACCME in its pursuit of an operational European system whereby each European doctor, whatever his/her country, is able to claim from his/her national authority the exchange of the credit points he/she was granted by attending a CME event abroad.

All information relating to the ACOE accreditation system is available online at [http://www.fecs.be/education/cme/index.shtml](http://www.fecs.be/education/cme/index.shtml) where a list of all accredited events is also available. Recently, it is possible for CME providers to apply for accreditation online. ACOE is also currently working on the issue of the accreditation of enduring material and is willing to cooperate with other interested parties on this matter.
7. **European Federation of Neurological Sciences (2005)**
   The Section of Neurology is working closely with the Federation to produce guidelines on the requirements for CME in the specialty.
   Works constructively with EACCME, is publishing new guidelines and intends to investigate on-line events
   Also follows along the same lines as the others.

   The Society has only individual membership of 5,000 and is in the process of developing stronger links with the National Societies.
   It has an annual congress, with an international audience and which provides both CME Credits as well as Certificates of Attendance. The last congress (attendance 11,000) was accredited by the EACCME and received a positive response from attendees, with 10% completing forms requesting CME credits.

9. **European Society for Microbial & Infectious Diseases (ESMID) (2001)**
   Is a Provider of CME with a Summer School and an annual congress.
   It has taken a similar approach to the cardiologists with a task-force on a CME Accreditation Board of the Section and Society with guidelines agreed.
   An on-line submission form is used on which quality is assessed. Intention is to become operational in Spring 2002.
   Small fee is intended on basis of number of participants:
   - 100 Euro  -------------- < 100 participants
   - 500 Euro  -------------- 100 – 1000 participants
   - 1500 Euro -------------- > 1000 participants

10. **European Association of Nuclear Medicine (EANM) (2003)**
    Three organisations are involved in CME, all three working together in a coordinated manner:
    - a) the CME Committee of the EANM,
    - b) the European School of Nuclear Medicine
    - c) the European Board of Nuclear Medicine.
The CME Committee of the EANM organises a CME programme that runs in parallel with the EANM Annual Congress. It is also involved in CME courses during the Annual Meeting of the Society of Nuclear Medicine in the USA.

The European School of Nuclear Medicine organises several courses during the year, mainly in the Eastern and Central European countries. The School also integrates into its programme courses and seminars that are organised on a national, regional or international level and that fulfil the criteria of the ESNM.

The European Board of Nuclear Medicine gives the credits (one hour, one credit) and corresponding diplomas after evaluation of the CME programme submitted by the provider. From case to case, the EBNM may also send observers to check the quality of the meeting. None of these bodies controls CME of individuals, this is left to national authorities, except for candidates for the European Fellowship exam who have to show proof of continuing education following national accreditation as specialist in nuclear medicine.


Runs an annual scientific meeting in association with USA Associations. The Annual Scientific meeting is held in a different member state each year and lasts for five days. The presentations (in excess of 1000) are all peer reviewed and published in Diabetologia.

The Postgraduate Education Committee of EASD co-ordinates a series of Euro-wide training courses across the member states each year. These are designed to facilitate local training and add value to local initiatives.

Leonard Harvey
March 2005
UEMS Liaison Officer and Past-President

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