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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 has established the European Accreditation Council for CME in order to give Europe a co-ordinated system to facilitate such activity, without encroaching on the responsibility of national organisations where they exist. Consequently, the development of national structures is being 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)

UEMS MEMBERS.

Austria (2004 - no new changes).

Since 2001, a new Medical Law has 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 had transferred the actual implementation of the programme 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. The system of weighting the content of CME events in a specialty will be abandoned and all points will have the same value.

A pilot-project "DFP-online Courses" has been approved in November 2002 (effective January 2003). In this project participation in certified interactive online internet-based CME activities will be 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.

Belgium (2004 - 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,
The system is **voluntary** but a number of **incentives** have been built in: 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 (20 hours 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.

Denmark (2004).

The system in Denmark remains a voluntary one organised 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 (2004).
No change – voluntary system with the majority participating but no exact figures.

A proposal for legislation of CME/CPD for health professionals has been made with a start-date for the new system of 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. 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. 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 the hospitals based on the specialty – this is under the control of the Ministry of Health.

Germany (2004).

In Germany there is an ongoing discussion to change the still voluntary CME to mandatory status. This discussion is driven by the Government and some Health Insurance agencies whereas, in contrast to this, the German Medical Association has tried to keep CME/CPD voluntary.

Due to the federal system, the regional chambers of physicians are responsible for CME in Germany. Although a harmonized structure for CME is a recommendation of the German Medical Association it is overseen by each regional chamber. Therefore the nationwide mutual recognition of credits by each regional Medical Chamber authority is an essential point of the recommendation.

Since the end of the 90ies, on recommendation of the Federal Medical Association, multiple Medical Chambers of the different states have run pilot-projects and regular systematic approaches for a voluntary CME/CPD–certification within a framework of open co-operation with the many Medical Scientific Organisations and/or MDs' Professional Boards.

The Senate for Medical Education of the German Medical Association has issued updated regulations for the accreditation of CME activities. The suggestion contains a catalogue of CME activities divided in 7 typical categories. These are: lectures and discussions, congresses, workshops with active participation, interactive education (print, CD, internet), self-study, hospitation and work as an author and/or lecturer. Due to the increasing importance of distance learning the maximum score for interactive learning is equal to the score for congress-visits (60 points in 3 years each).

The basis for gaining a CME-certificate is related to a maximum collecting period of three years with a minimum of 150 credits.

Some statistical data (all numbers approx.):

- overall 301.000 MDs practising,
- 131.000 ambulatory care,
- 143.000 hospital care,
- 10.000 different public services,
- 15.000 other.

MDs have usually to pay for their CME-activities by themselves, industrial sponsoring is restricted to certain rules by 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.

A new Social Security Code V, which is effective from !st January 2004, makes CME mandatory for MDs within the Association of Panel Doctors (§ 95 d) and further strongly recommends for MDs in hospitals ("structure of the quality including the to be fulfilled CME-proofs of M.D.-specialists") contained in § 137 of Social Security Code V.

There is an obligatory surveillance by the Association of Panel Doctors. The CME-proof is to be shown 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 Association of Panel Doctors (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

Cut off from fees stops at the end of the quarter of the year, after the completed CME-proof is shown officially.

- two years after the five years period: withdraw of accreditation / contract

It is laid down in § 95 d of 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. At this moment the Medical Chambers try, along with

the Scientific Medical Associations and Medical Professional Boards, to help the individual MD to fulfil her/his need of coping with the legal requirements.

From the point of view of the Medical Chambers the voluntary CME-certification–circle (maximum three years – minimum 150 credits) is still offered and put to good use – thus applicable to show up active CME-proof during the mentioned five years' period.

Some of the Medical Chambers are considering an intensified offer of web-based CPD (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, for instance, is offering a special, multi-lingual IT-CME-platform).

Via the Medical Chambers, a systematic approach is discussed for MDs to have an individual on-line-credit-account to serve 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.

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 normally fully accepted by the Medical Chambers of the States within Germany along with the German Federal Medical Association

Greece ((2004 - 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 Pan Hellenic Medical Association and the Scientific Societies on regulation and financing of CME/CPD.

Funding remains the major problem.

Iceland (2004).
There is a possibility that a formal accreditation system may commence in 2004. It will be run by the Icelandic Medical Association and supported by the University of Iceland.

It will be an entirely voluntary system.

Ireland (2003).
A change to the Medical Practitioners Act is being rewritten at present. 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 accommodate 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 the general public and the regulatory body of the maintenance of ones' competence to continue as a medical practitioner.

The Irish Medical Council (**Regulatory Authority**) 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 will apply to all doctors from 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.

It has also decided that in June 2003 50% of registered doctors will be required to show participation with the remainder in June 2004.

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 recently 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 (2004).

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 150points/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.

In 2004 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 (2001).

CME systems exist that are controlled by the profession and entirely **voluntary**.

Netherlands (2004).

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

Re-registration with a 5-year interval is required for medical specialists, the first term being implemented in 2003. The implementation is supervised by the Ministry, but carried out by professional bodies, the Registration Committees. The requirements are limited to the type of practice, although continuing education requirements will be effective in the future. Presently this is not the case pending a difference of opinion between the ministry of health and the physicians concerning the awarding and ear-marking of financial means for continuing education in health care budgets and fees.

Independent from the legislation the more than 30 professional societies in the separate specialties, general practice, occupational medicine and public health have developed systems for accreditation of educational activities and the awarding of credits for their members since the early nineties. These systems are valid for their own members only and are not connected with penalties in the case of non-compliance except counseling. However, the professional societies put pressure on their members and continuing education plays a role in the process of peer review by visitation.

There is no structural interconnection for mutual recognition between the societies. In 2002, the Royal Dutch Medical Association (KNMG) took the initiative to establish an umbrella structure and system of joined accreditation of educational activities and mutual recognition of continuing education credits for all physicians. In 2003 the

professional societies reached an agreement in principle to establish such a system. The KNMG will facilitate an independent structure ("Accreditation Overleg"), which will implement the mutual recognition. All professional societies have yet to approve formally their participation in this structure and authorize the Accreditation Overleg to act on their behalf, among other things concerning mutual recognition of EACCME credits.

Presently the professional societies are participating separately in the process of European accreditation through the EACCME.

In summary: the present **mandatory** legal system applies only to re-registration on the basis of type of practice - "regular practice of the specialty". The link with the professional continuing education credits has not been made.
70-80% of all doctors comply with the current CME requirements, 75% of which is provided by the Specialists Societies.

Norway (2004).
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 (recognized 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 NMA conducted a pilot study during 2002 to document specialist CME activity in 2 hospitals and in Ophthalmology in one county. This pilot study in 2002 revealed that specialists are not accustomed to plan their CME activities, and it therefore took time to establish an educational plan. The most difficult part of the project was the peer-review. This was an unusual way for communication between doctors and they had problems deciding against what parameters the evaluation should be made.

The financing of CME activities has also been an impediment. The conclusion was that as a system and a method this can function, and that it is possible to establish a more formal CME which can be documented. However, we need better tools, help with the peer-assessment process, and it is necessary to define the objectives for the CME activities in each specialty as a basis for the evaluation.

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

The National Council for specialist education in Norway has in spring 2003 delivered a recommendation to The Ministry of Health about a more formalized and documented CME for medical specialists. It is not recommended to establish a re-

certification system, but it is recommended to establish 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 The Ministry decides upon a national system for CME.

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.

Spain (2004).

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 of 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 actively working at the present time. They have signed a mutual agreement for recogbition of credits with UEMS EACCME.

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

Sweden (2003).

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 budget 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 (August 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 will support the healthcare's need of continuing professional development of physicians. Its main service will be 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 will announce all approved CME/CPD events in Sweden, will be launched during 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 Helveticorum, 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 (2004).

The term “CME” has now been largely superseded by “CPD” and continues to receive much attention in the UK.

CPD is virtually mandatory but not legally so.

The General Medical Council **(the national medical regulatory body)** has devolved the administration of CME/CPD activities to the Royal Colleges, which are now being linked in the Academy of Medical Royal Colleges (Directors of CPD Committee), which has drawn up a framework document. All demand a set level of CPD activity over a period of time (250 credits/5 years). Such activity is divided between external (conferences etc.) and internal (local and self-directed) CPD. Each College is independently responsible for maintaining and monitoring the activity of its members and a number co-operate with joint registration schemes.

Attention is also being paid to **peer review** in the assessment of individual CPD, particularly in General Practice, for instance by visitation. The problem is the huge expense of peer review systems.

In addition the General Medical Council is introducing an **annual revalidation** system of all licenced practitioners in which CPD activity and their annual appraisal will be an important constituent. To be introduced in 2004 and it is possible that it will be phased in progressively.

Furthermore, in every hospital a new procedure called **"clinical governance"** has been introduced which is the responsibility of the hospital Chief Executive 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). Unfortunately, when the government uses the term “appraisal”, review and profile of practice is sometimes meant. Appraisal is a contractual obligation and being extended to non-consultant grades as well as trainees.

The greatest problem is lack of hard facts in profiling a doctor's practice – how much, how often, quality, etc.

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 (2004 - 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 and an Institute of Licensure and Re-licensure was established. Thus the Chamber also became the National Authority for CME/CPD.

That year 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.

Cyprus (2004).

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 unexpectedly high. From 1st January 2005 it will become **mandatory** under a special law although the system will continue to be run by the Cyprus Medical Association.

Registration and documentation of CME activities are 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 will be given to those doctors who will have collected 150 credits. The validity of this certificate will be 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.

Czech Republic (2004 - no new changes).

CME/CPD is **mandatory** in the same way as Croatia with the law establishing the Medical Chamber (to which it is compulsory to belong) as the National Accreditation Authority. It accredits another body to actually manage the process and award credits. There is also to be a new law on post-graduate education to emphasise that it is mandatory. 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.

Hungary (2004).

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.

As regards specialists, there were too many, but now not so, as poorly paid and emigrating with a reduced number remaining in hospital.

The Medical Chamber is the National Accreditation Authority and has organised a body for awarding points through the Scientific Societies (who are rather lax) and registration is poor due to lack of finance.

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.

Slovakia (2004).

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 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 systém will be adopted in the shortest possible time and all preliminary activities have been started.

Slovenia (2004).

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). Anyhow we feel that, at a time of conflicting views and opinions regarding the relevance of collecting CME/CPD points, this is 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 meeting 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, we awarded credit points to 248 organisers of domestic professional meetings and 500 individual applicants. More detailed analysis of our 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 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. To connect somehow the process of recertification and CPD we are making efforts in finding the proper way to award certain (important) amount 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.

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 (2004).

Theirs is a provider-based system with some 2,500, 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.

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 24 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.

Currently working on 2 new issues:

- performance-enhancing activities for quality assurance and good feed-back
- Internet activities of 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.

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.

Interested in attempting to establish global standards for CPD.

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) (2004).**

   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 by 3 independent evaluators following strict guidelines.

   Over 20 web-modules have been approved for LDL.

   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.

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.
It was proposed that CME Credit points be awarded to participants in the European Congress of O & G and this was applied to the European Congress in Malmö in 2001 and will also be the case for the European Congress in Prague, 2002.

3. European Board for Accreditation in Pneumology (EBAP) (2004).

This has been established since 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 2-4 years. Its aim is to concentrate on quality control and facilitating of CME/CPD events. It does not approve providers, only events.
From 2002, all requirements are based on EACCME criteria and are very strict regarding commercial support.
The Board has established its own web-site, www.ebap.org, which will be 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

5. European Board of Vascular Surgery (EBVS) (2002).

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) (2003).**

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 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 (2004).**

The Section of Neurology is working closely with the Federation to produce guidelines on the requirements for CME in the specialty. Also follows along the same lines as the others.

8. **European Respiratory Society (2002).**

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 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.

11. European Association for Study of Diabetes (EASD) (2001).

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.

12. <u>European Association of Dermato -Venereology (EADV) (2001).</u>

Observing only.

Leonard Harvey. March 2004.
UEMS Liaison Officer and Past-President.

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