Report on the Current Situation of CME Accreditation in Europe
1 Executive Summary

When it was created in 1999, the European Accreditation Council for CME (EACCME) was set up on the principle that National Accrediting Authorities (NAAs) would encourage a structure making CME credits in Europe exchangeable, provided that they would remain in charge of events in their own country. The expertise of UEMS Sections/Boards would be used for consultative purposes to complement the decisions of the NAAs. At the time, the UEMS decided that EACCME should not develop as a stand-alone body, with representatives from all stakeholders of the system, but should remain firmly within the realm of UEMS.

Rapidly, some specialties recognised the importance of European CME accreditation and decided to develop dedicated bodies (European specialty accreditation boards) which would be responsible for assessing events. Those were mainly created as joint ventures between a UEMS Section and the corresponding European scientific society. Initially, such initiatives were highly encouraged by EACCME, which saw this as an opportunity to build an efficient system which might spread to more and more specialties.

As usual in any new system, a wide range of issues rapidly arose with respect to workflow, deadlines, fees, accreditation of distance learning activities, accreditation of providers for a specific duration, etc.

EACCME annual reports since 2001 have mentioned these issues as deserving "further consideration". However, many of them have not yet been resolved. Current causes for concern include:

√ EACCME guidelines including D9908 on quality criteria, have neither been updated nor clarified since their creation in 1999. Furthermore, the actual enforcement of these guidelines has never been monitored, an issue which is very well illustrated by the results of a survey performed in the summer 2006 among all stakeholders of the system.

√ Relations with the pharmaceutical industry have never been clearly defined. Initially, it seemed that "unbiased education" referred to events organised by recognised scientific bodies, universities etc. only, and not to events organised by the industry. However, there seems to have been a recent shift in EACCME's position in which the possibility is being considered that events organised by the industry may be accredited (e.g. satellite symposia). This has however never been officially communicated nor discussed with the main stakeholders in CME accreditation.

√ No significant investments into the system have been made, even although EACCME revenues have risen from EUR 10’000 to EUR 100’000 in just five years. It is also not clear how the revenues are used.

√ Within six years, the number of events has increased from 100 to over 600, but the IT infrastructure has not improved proportionately. Applications are still processed manually.

√ Relations with European accreditation boards, which have invested time, energy and money in developing efficient working procedures and transparent guidelines, have also deteriorated since some of their initiatives have been considered by UEMS as potentially harmful to EACCME.

√ Since the inception of EACCME, there have been no attempts to apply for EU funding, even though continuing education is a priority on the European agenda, whereas some individual specialties have obtained EU funding to develop and disseminate their own systems. This
suggests that UEMS/EACCME, as a central organ representing 2 million doctors, would have been well-placed to receive grants from the EU to develop a harmonised system\(^1\).

These issues, and others, explain why the survey which has been performed among all stakeholders of the system reveals that, while the existence of EACCME is in no way questioned, most of its working procedures are felt to be out-dated; overall response with regard to guidance provided by EACCME - around 50 percent of the respondents always or mostly satisfied, around 50 percent satisfied only sometimes, seldom or never; over 60 percent of respondents not satisfied with the current manual processing of application; almost 80 percent in favour of a common internet platform, etc.

Looking back over the past 6 years, it thus seems that EACCME has successfully managed to initiate operations, and to create the basis for a credible European system, but has not engaged effectively in further development and modernisation of the system.

Clearly, if European doctors wish to maintain their own CME accreditation system, they have to restore its credibility as quickly as possible and must start to collaborate in an efficient and open way – even if, for some of them, this may mean making concessions.

This document tries to provide an accurate overview of the current situation while offering suggestions as to how to improve the system in order to obtain an efficient, trustworthy and harmonised European system. It should be considered as a basis for constructive discussion on the future development of the European Accreditation Council for CME.

\(^1\) For example, over the summer, the EU issued a call for proposal entitled: "Call for proposals EAC/33/06 - Award of grants for the promotion and coordination of projects to develop Credit Systems for Vocational Education and Training (ECVET)", which would have perfectly matched our aims and objectives.
2 Fundamental principles of European CME accreditation

Over the last decade, European accreditation has been developed to meet pressing needs for the accreditation of educational events and products which are targeted at a world-wide audience rather than at doctors of one specific (host) country. The creation of the new system of accreditation was designed to respond to the needs of a wide range of stakeholders:

a) **National Accreditation Authorities / National Medical associations**, which bore the responsibility for ensuring that their doctors were fit to practise and thus well-trained and well-informed and which thus had to ensure that all CME events attended by their doctors, whether within their own country or abroad, were of high educational value.

b) **Doctors**, who more and more often needed to collect recognised CME credits to fulfil the requirements set by their national authorities (see above). Their main concern was to have access to high-quality CME corresponding to their specific needs and interests, with as few geographical barriers as possible. Due to a steady increase in the number of international conferences, congresses and courses, doctors increasingly tended to travel to CME events abroad, and therefore needed an efficient system allowing them to perform CME abroad and easily to validate the credits they had obtained upon their return to their home country.

c) **CME providers** (international providers such as European Scientific Societies or, less frequently, regional providers) regularly organised events which did not specifically address the needs of doctors from a specific country, but those of a world-wide audience. They therefore needed a system allowing them to obtain internationally recognised credits for their events.

Further, CME providers were starting to offer educational opportunities other than live events, for example through e-learning, CD-ROMs, educational journals etc. They therefore needed a system allowing them to provide recognition (i.e. CME credits) to those doctors who chose these materials to perform their CME.

Based on what had already been developed in the United-States more than two decades earlier, the European Accreditation Council for CME was thus created in 1999.
3 Overview of Current situation

3.1 Bodies involved in European accreditation

3.1.1 EACCME

In October 1999, EACCME was established by the Management Council of the UEMS whose purpose is the harmonization and improvement of the quality of specialist medical care in Europe. EACCME started operation in January 2000.

EACCME was set up as a UEMS body and is governed by the UEMS Council, which is made up of the representative professional specialist associations in the member countries of the European Union and associated countries. It is managed by the UEMS Executive Committee.

EACCME also has an Advisory Council which links the accrediting bodies participating in the process. Partners in the Advisory Council are the National Accreditation Authorities and UEMS Specialist Sections and Boards. Some European scientific societies are also invited to the meetings.

Currently, EACCME acts as an umbrella organisation. Its role is two-fold:

a) **Strategic / political**: in that role, EACCME is responsible for setting the rules for European CME accreditation and monitoring their application.

   Quality assurance criteria mentioned in the EACCME D9908 (July 1999) pertain to: the display of commercial interests; the guarantee of non-biased education; attendance control; post-event reports from providers; feed-back from participants and self-assessment possibilities both for the provider and the participants.

b) **Operational**: in that role, EACCME acts as a clearing-house for the accreditation of international events. It collects all applications and then forwards them to:

   a. The appropriate NAA.

   b. The appropriate specialty (UEMS Section/Board/specialty accreditation board, see below) for expert advice and assessment.

Its task is then to collect the responses from both bodies and to inform the provider of its decision. However, the operational procedure involving these boards remains ill-defined. It is not clear to an outsider whether an application sent to EACCME is forwarded to a NAA and/or a specialty board and which assessment is followed in the case of conflicting results. EACCME can overturn the decision of a specialty board without further consultation.

This process is currently performed entirely manually and is managed by the UEMS Secretariat with insufficient administrative resources. In a rapidly expanding field, this may seem an unfair burden on the people involved.
EACCME has also introduced the ECMECs (European CME Credits), where 1 credit = 1 hour of education. EACCME has set a rule according to which NO event can be awarded more than 3 ECMECs for ½ day and 6 ECMECs for 1 day of education.

### 3.1.2 NAAs

NAAs are responsible for setting the rules to be followed by doctors in their country (statutory significance of CME, number of credits to be collected each year, etc). The statutory significance of CME varies from country to country:

#### 3.1.2.1 Current Status of Accreditation in individual countries

**Legal obligation:** Austria, Croatia, Czech Republic, France, Italy, Netherlands, Poland, Romania, Slovenia, Switzerland

**Professional obligation:** Germany, Ireland, Spain, UK

**Financial incentive:** Belgium, Norway

**Voluntary:** Bulgaria, Cyprus, Denmark, Finland, Greece, Hungary (for specialists), Iceland, Luxembourg, Portugal, Slovakia, Sweden, Turkey²

Currently, National Accreditation Authorities are also responsible for reviewing / accrediting all CME events taking place in their own country (whether regional, national or international). Being part of the UEMS system, they are free to recognise the credits awarded by other National Accreditation Authorities and the European credits issued by EACCME.

It is to be noted that some countries apply neither the 1 credit = 1 hour of education rule, nor the principle of "no more than 6 hours of education per day". Therefore, the numbers of credits issued by a NAA and by EACCME frequently differ. Different rules apply also across Europe concerning the accreditation of ‘satellite’ symposia at congresses organised by the industry.

### 3.1.3 UEMS Sections

For each specialty recognised by the UEMS, its UEMS Section comprises two representatives per country. In the accreditation process, these Sections provide expert advice to the EACCME central office, i.e. they are asked to assess submitted events within their specialty and to issue a recommendation on whether or not the event should be approved and on the number of credits it should be awarded.

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² Ref : UEMS presentation made by Dr B. Maillet at the UEMS meeting in Copenhagen, Sept. 2005 and Serono Symposia International [http://www.seronosymposia.org/cmeworld/cmeworld.ihtml](http://www.seronosymposia.org/cmeworld/cmeworld.ihtml)
3.1.4 UEMS Boards

UEMS Boards are working groups of the specialty sections and are composed of representatives of national professional, scientific and academic organisations. Their remit is primarily to monitor education and training standards. In some cases the Sections and Boards have amalgamated into a single body.

3.1.5 European Specialty Accreditation Boards (ESABs)

In the past 5 or 6 years, various individual specialties have established European Specialty Accreditation Boards (ESABs). ESABs are operated by individual UEMS Sections/Boards, European Specialist Societies/Federations or jointly by these organisations. Their sole activity is to provide review, evaluation and international/European CME accreditation for events in their own specialties. ESABs operate according to the EACCME Quality Criteria as defined by UEMS document D 9908. ESABs are different from UEMS Sections and Boards in so far as they function more independently from UEMS and they thus charge their own fees. Some specialties, which are not recognised within UEMS (e.g. haematology, oncology), have also successfully created their own accreditation boards.

Depending upon the structure in place in each specialty, the UEMS central office deals with the representatives of a UEMS Section, of a UEMS Board or of an ESAB. Based on its own (administrative) criteria, the UEMS central office can then either approve or over-rule the decision made by the UEMS Section/Board/ESAB without the need for further justification. In cases of conflicting assessments by a NAA and a specialty board, EACCME seems in most cases to follow the assessment of the NAA without communicating its decision to the specialty board.

3.1.6 Agreements between different stakeholders

As of December 2005, EACCME had signed formal mutual recognition agreements with:

**UEMS Sections:**
- Dermatology and Venereology
- Paediatric Surgery
- Physical and Rehabilitation Medicine

**National Accreditation Authorities:**
- Cyprus Medical Association
- Medical Association of Malta
- Pan-Hellenic Medical Association
- Royal College of Physicians of Ireland
- Royal College of Surgeons of Ireland
- Spanish Accreditation Council for CME

In the year 2000, EACCME also signed a pilot agreement with the American Medical Association (AMA) towards mutual recognition of CME credits. This pilot agreement is due to come to an end in 2006. The UEMS website currently contains no information as to this agreement’s continuation or termination, but the latest information obtained suggests that this agreement has now been renewed,

### 3.2 Practical Operation of Accreditation

#### 2.2.1. Accreditation of live events

This is the main accreditation activity. UEMS/EACCME issued a set of general rules in 1999, which are still valid. Those pertain mostly to quality criteria which should be respected (see section 3.1.1 above and section 5.2 below). In Event Accreditation, each individual event is evaluated before it takes place in contrast with Provider Accreditation in which providers are evaluated on the basis of their previous activities and if found satisfactory are accredited to provide educational events and materials for a further defined period of time (see later).

#### 3.2.1 Accreditation of distance learning, CD-Roms etc.

Currently, EACCME does not accredit any on-line learning, CD-ROMs or educational journals.

A UEMS article from 2001 specifies:

> In November 2001 a Working Group with representation from the UEMS Advisory Council on CME was established to study other CME issues. The recommendations of the Working Group were forwarded to the UEMS Management Council meeting in October 2002 (Document D 0250 rev1). These included, as documented in the EACCME Annual Report of 2002 (D 0306):

- Accreditation of distance learning programmes.

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

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

  “- recommends to Management Council that EACCME award accreditation, as a pilot project, in a limited number of instances .... to professional organisers of CME activities.”

Another one from 2002 mentions:

> There is pressure to incorporate various modalities of distance learning including printed materials, audio and visual, CD-ROM, and web-based
programs. This was not authorized by the national CME authorities at the start of the operation of the EACCME. Each of the national authorities will need to be approached in order to incorporate these types of activities.

It is clear that the importance of distance learning and provider accreditation was recognised as far back as 2001/2 with specific recommendations being made to Management Council in relation to each of them. Despite that, UEMS/EACCME has not resolved these crucial issues in CME accreditation over the past five years, and has left the European distance learning market open to American CME providers.

### 3.2.2 Fees

EACCME applies a sliding scale for all events it accredits. It has now proposed to use the same sliding scale, with a repartition of 1/2 for itself, and 1/2 for the UEMS Sections/Boards which provide the quality assessment. EACCME has now also started to collect a fee which is then paid to NAAs which have signed a Mutual Recognition Agreement with EACCME. Fees for providers are then again increased by 1/3 (see table below). It is also worth mentioning that Sections/Boards are not paid if they take more than 3 weeks to perform the assessment. It should be noted that this 3-week rule only applies to Sections and Boards, not to the EACCME central office or to the NAAs, which are paid in any case.

There was also a rule saying that, should a NAA or a Section/Board/ESAB not reply within 3 weeks, the request would be automatically accepted by the EACCME. However, taking into account the frequent delays in EACCME’s decisions (up to 3 months for requests already validated by a Section/Board/ESAB), it is not clear if this rule still applies.

The current sliding scale used by the EACCME is as follows:

<table>
<thead>
<tr>
<th>Number of Participants</th>
<th>Fee for UEMS – EACCME®</th>
<th>Fee for the Section (if agreement signed)</th>
<th>Fee for the NAA (if agreement signed)</th>
<th>Total amount of the invoice to be paid by the Organisers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 250</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>300</td>
</tr>
<tr>
<td>251 - 500</td>
<td>200</td>
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<td>501 - 1000</td>
<td>300</td>
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<td>1001 - 2000</td>
<td>400</td>
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<td>1200</td>
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<tr>
<td>2001 - 5000</td>
<td>500</td>
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<tr>
<td>More than 5001</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
<td>3000</td>
</tr>
</tbody>
</table>

In 2005, EACCME accredited a total of 604 activities for a total amount of EUR 102,784.64.
4 Survey on European CME

4.1 Introduction

In June 2006, three European scientific societies organised a workshop in Brussels to discuss European CME accreditation. It was attended by representatives of 13 different medical specialties (UEMS sections, CME specialty accreditation boards, European societies).

Over two days, a wide range of issues linked to European CME accreditation was discussed, such as evaluation criteria, assessment methods, distance learning, event vs provider accreditation, etc.

In that meeting, there was a strong feeling that the opinion of all stakeholders involved, including all 39 UEMS specialties, national accreditation authorities and international CME providers should be sought before making any proposals as to how to adapt and improve the current CME accreditation system. Three separate surveys containing similar questions were thus prepared and sent to the different groups of respondents (a: UEMS Sections and Boards, b: NAAs, c: CME providers).

4.2 Analysis

4.2.1 Respondents

In total, 44 representatives of UEMS Sections and Boards, representing altogether 28 different specialties, 29 representatives of National Accreditation Authorities, representing altogether 11 countries (and different Bundesländer in Germany) as well as 107 respondents representing providers entered the survey.

In addition, the answers of 8 representatives from Serono Symposia, who completed the survey dedicated to NAAs, were dismissed.

See annex I for a complete list of respondents.

4.2.2 Accredited activities

S&Bs and NAAs were asked to state which kind of activities they currently accredit, and which kind of activities they plan to accredit in the future. Similarly, providers were asked to state which kind of activities they currently provide, and which kind of activities they are planning to provide in the future.

It is interesting to note that a majority of each category of respondents mentions e-learning activities as an activity which will be accredited / provided in the future, thus clearly showing the growing importance of that field. Further activities mentioned include textbook chapters, credits for reviewing activities, and national events.
4.2.3 Length of accreditation process

Regarding the length of the accreditation process, all respondents were asked to estimate timeframes which would be ideal/acceptable/not acceptable. It should be underlined that there is an overwhelming consensus that the entire process should ideally not take more than 1 month, but that, more realistically perhaps, a duration of 1-2 months is still acceptable. However, there is an equally strong consensus that a duration of more than 2 months is not acceptable.
S&Bs and NAAs were then asked to state how much time they usually need to perform an accreditation. As for providers, they were asked to state how long it usually takes for their activities to receive European accreditation.

It is interesting to note that, although an overwhelming majority of both S&Bs and NAAs say that they need between 1-3 weeks or between 3-5 weeks at maximum to perform their review, a majority of providers mention that it takes more than 5 weeks for their activities to be accredited. Three factors could explain this discrepancy between the replies of S&Bs/NAAs and providers:

- S&Bs and NAAs are somehow optimistic on the time they need to perform their reviews;
- Contrary to UEMS/EACCME rules, the double-accreditation process is not performed simultaneously, but sequentially;
- The manual processing within the central UEMS/EACCME secretariat slows down the process.

Compared with the needs for a quick accreditation process expressed in the previous question, this clearly shows that an improvement in the way the process is currently performed is necessary.

![Graph showing the degree of implementation of quality criteria]

### 4.2.4 Quality control

As mentioned later in Section 5.2.4 to 5.2.8 below, back in 1999, UEMS/EACCME issued a set of recommendations regarding quality criteria by which accreditation should be governed (D9908).

The following graphs show the degree of implementation of those criteria seven years after they were issued.
These graphs clearly show that, at least some providers have implemented the quality criteria issued by UEMS/EACCME, but they are only exceptionally observed by NAAs and by S&Bs. This indicates that 7 years after the system was introduced, accreditation is still provided mostly on the basis of preliminary programmes and not on the basis of site visits, feedback provided by participants during previous activities, etc.
As an umbrella organisation, UEMS/EACCME should be responsible for ensuring that those criteria are applied before granting accreditation. Logically, UEMS/EACCME central office should monitor the implementation of the criteria directly, thus requiring and assessing post-event reports, feedback forms, etc. or it should devolve that responsibility to S&Bs and NAAs, which should in turn be required to collect and assess the above-mentioned documents. In order to ensure a minimum of quality control, Mutual Recognition Agreements proposed by UEMS/EACCME should for instance include a section ensuring that these rules are respected.

4.2.5 Discrepancies between specialties and countries

All respondents were asked to state whether or not they were satisfied with the discrepancies that have been observed in the accreditation process between all specialties and countries.

Clearly, a majority of respondents (even 60 percent of the NAAs) are not completely satisfied which suggests that there would probably be room for negotiations to try to implement more uniform ways of working throughout Europe while respecting the prerogatives of each NAA.

4.2.6 Manual processing of applications

All respondents were asked to state if, in their opinion, the current manual processing of all applications through a central office, followed by a different procedure in each S&B/NAA, was satisfactory. Here again, there is a strong consensus among all categories of respondents that it is not really, or not at all, satisfactory.
Again, this shows that there would most likely be room for negotiations to implement a more standardised, electronic-based working procedure (see below).

4.2.7 Common internet platform

Following on the previous questions, respondents were asked if they would agree to work on a common internet platform where all the relevant parties could perform their part of the work, thus making the process quicker and more transparent.

As a result, over 80 percent of the respondents, in all categories, responded "yes, in any case" or "yes, why not". This clearly shows that developing an Internet platform taking into account the needs of the different parties involved could very well be successful (see proposals drafted in Section 5.2.1).
4.2.8 Guidance provided by UEMS central office

All respondents were asked to rate their satisfaction regarding the guidance they receive from UEMS with respect to how the accreditation process is performed, which rules and deadlines apply, etc. S&Bs expressed the most satisfaction, followed by NAAs and then by providers. While around 50 percent of the respondents were always or mostly satisfied, around 50 percent were satisfied only sometimes or even seldom or never (20 percent of the providers). This could clearly be improved quickly by issuing and disseminating a more detailed set of user-friendly, graphically appealing guidelines (for instance through an updating of the 1999 documents).

4.2.9 Role of EACCME

All respondents were asked to state whether or not they would agree with a system in which UEMS/EACCME would keep the role of a policy-maker, mandated to issue the rules and to monitor their implementation, while S&Bs and NAAs would be responsible for all operational aspects of accreditation.

There was a strong consensus among all categories of respondents to accept this sharing of responsibilities.

This reinforces the concept of a harmonised internet platform, which would be maintained by UEMS/EACCME, which would thus have access to all information, but without having to interfere manually for each request.
4.2.10 Provider accreditation

Finally, respondents were asked if they were interested in moving towards a system of provider accreditation, in the light of the increasing workload of European accreditation.

There again, it seems that there is considerable interest in examining this option, thus making it realistic to envisage pilot projects.
4.2.11 Open comments

Open comments from respondents provide some useful information on how they view the current system, and on how they envisage its future. We provide below all received comments without any modification.

S& Bs

I think it is very important not to adopt any system that is very proscriptive as this will become the stick with which we will have to beat ourselves with. It is a persistent annoyance created by many different departments in the EU to create new rules and to oblige everyone to obey them many with little advantage other than more expensive beaurocracy. In ophthalmology it is working quite well and has become more streamlined with the cooperation of UEMS.

1) Guidelines or advice about Industry Symposia, often of high level, with hidden industry advertisement, 2) Improved control of learning: electronic questionnaires may be prepared, to be filled at home, to receive the credits (which could be distributed electronically and not at the end of the Congress).

I favour a reformed EACCME comprising stakeholders including national authorities, specialty accreditation boards, UEMS, medical schools and trainees. I consider event accreditation should be replaced by provider accreditation along the American model.

Since there has been only one false submission, which was not evaluated, my answers cannot be used AT ALL for any statistical or descriptive analysis.

1. Avoid different CME points given by the UEMS and the National Authorities! 2. We need a common internet platform of the individual CME points collected by the individual doctors in his individual country. In a common Europe with doctors allowed to migrate from one country to another the CME accreditations by the National authorities should be processed online!

Our Section has still only very short and recent experience on European CME accreditation.

Keep it lean! Not too burocratic! Evaluate its efficiency and effectiveness!

Must be simple and swift to operate. Must have clear policy re. industry. Must avoid fixed points such as 6 points per day even if the vent is 8 hours. Must be based on count of actual presence at any event (session attendance registration)

In Cardiology EBAC do the practical work, On site inspections etc. The policy should be drawn by EACCME and UEMS Centrally.

Confusion exists because of the fees involved and EACCME is currently a step too many in the approval process. It could be carried out much more quickly by those in the specialty who will probably know the event before it even comes for approval. The system smacks of being a cost accrual process.

At present it seems to be working fairly well in Nephrology and the mutual recognition between EACCME and the American Medical Association is important.
NAAs

The public would need much more information about the system and European law should allow to enclose all federal and local activities to harmonise the system for all European citizens.

As specialist society the Professional Board of German Surgeons (PBGS) supports the idea of decentralised, provider-driven accreditation of CME events. We would be pleased to be involved in further activities. We are able to provide a huge experience on distance learning projects. The PBGS runs an E-learning site with more than 300 courses online. A lot of them are CME-certified.

It is time to come towards fruitful conclusion. It should not be a question of egoism or who out of different "European" medical organisations is the most important. This is not constructive. Honestly, I am sure, that all the so-called European Scientific Societies are too much influenced by the industry, i.e. what could represent important bias in accreditation. This should stay at the level of the UEMS, really non-profit organization, which is financed exclusively through the fees paid by the member National Medical Associations. Anyway, UEMS should improve its system of handling the materials...

Providers

do not know that there is a CME accreditation system for neurosurgery and therefore these questions become futile

European curriculum European exchanges during training period

No further suggestions for the moment.

Internet platform seems to be absolutely necessary to increase efficacy of accreditation procedure and in the diffusion of information

National accreditation is probably unavoidable for a long time and mutual recognition within European Union the easiest solution according to common rules and criteria edicted by UEMS-EACME. In anesthesiology, in France, the French College of Anesthesiologists (CFAR) provides a very good organisation since more than 10 years.

5 Strengths and weaknesses of current system

5.1 Introduction

European CME accreditation started slowly in 2000. Since then however, it has gained momentum. In 2005, over 600 activities were accredited by EACCME.

Up until now, each country as well as each Section/Board/ESAB has been given a good deal of leeway to develop its own procedures, internet portals, fees, etc. However, due to the increasing importance and significance of European CME accreditation, a number of issues have arisen which require urgent consideration.

√ EACCME was created as the European equivalent of ACCME. However there are fundamental differences between Europe and the USA which have hampered the development of EACCME. Unlike USA, Europe is not a single country, speaking one language and governed by a uniform code of practice. The principle of subsidiarity is widely
accepted whereby individual countries are responsible for many of their own affairs. UEMS is not accepted by European doctors as their professional association in the same way that American doctors accept the AMA. Therefore when the AMA set up ACCME, the individual state medical societies reacted more cooperatively than did the European countries when UEMS created EACCME. In Europe EACCME has had to confine its activities to international events since subsidiarity dictated that national events were solely the responsibility of the NAAs of the host country. Although EACCME often, but not always, asks the UEMS sections to evaluate international events, it is politically expedient to ask NAAs for their assessment also. Therefore many international events are assessed twice. Even when accreditation is awarded in this way, there is no guarantee that other European countries will recognise the credits awarded by EACCME. Furthermore the double reviewing process is performed without any communication between the Section/Board and the NAA. The two groups of reviewers often come to different conclusions leading to great confusion among providers. There are also examples where EACCME asked only a NAA for assessment of an international event without involving a UEMS Section/Board/ESAB, thus adding to the confusion about the proper accreditation process.

√ The principle of subsidiarity is so potent in Europe that it could be argued that EACCME should simply accept the accreditation decision of the NAA of the host country where an international event is held and just disseminate the decision throughout Europe in the hope that other countries will recognise it. The argument against this proposition is that there would be little hope of uniform quality control in European CME. There would be no standards to which CME providers should adhere nor would there be any attempt on a European level to monitor the effects of different types of CME on clinical practice. In contrast, in the USA which operates on provider rather than event accreditation, ACCME insists on rigorous appraisal of individual providers which includes participant feedback, attendance control and strict measures to prevent inappropriate commercial influence.

√ The present system depends on manual processing of all applications carried out centrally in the Brussels UEMS office. If the number of applications continues to rise, the capacity for manual processing may be overwhelmed.

√ Lastly the present explosion in distance learning for which accreditation is currently not available requires urgent attention to avoid providers turning to the USA for accreditation.

The following chapters will try to analyse these different aspects and to provide suggestions for improvements to the current system.
5.2 Analysis

5.2.1 Processing of applications

5.2.1.1 Current

The application process is currently performed entirely manually. The many steps (provider to EACCME, EACCME to specialty and NAA, specialty and NAA back to EACCME, EACCME back to providers) thus involve at least 6 emails per application (without taking into account the contacts between specialty and NAA administrations and their reviewers). Occasionally even paper documents are received from EACCME for forwarding to reviewers.

It should be noted that, with over 600 activities within one year, this means no less than 3600 emails, i.e. on average 16 per day. The absence of automatic notifications, forwarding, reminders etc. strongly increases the risk of omissions, delays etc. Moreover, manual processing enhances the risk of misdirecting applications (i.e. sending them to the wrong specialty), thus leading to further confusion and delays.

5.2.1.2 Suggestion

In the short term, create an internet portal allowing all providers to apply directly online to the specialty of their choice (relevant UEMS Section/Board or ESAB) and to the relevant NAA. This will facilitate access to accreditation services for CME Providers, while speeding up the process and making it much more transparent.

In the mid-term, a common interactive management system for all specialties should then be put in place.

5.2.2 Deadlines

5.2.2.1 Current

EACCME recommends that applications be submitted three months in advance. Unfortunately, many providers tend to send in their applications only a few weeks before the event takes place. They have not realised that the sooner they apply, the better use they can make of their European accreditation, for promotion purposes for instance.

According to its procedures, EACCME is supposed to receive all applications, which should immediately be forwarded to the relevant Section/Board/ESAB and NAA. However, from our experience, it seems that, due to the lack of any automatic processing (see above), the forwarding of applications is frequently delayed or sent only to a NAA.

With regard to the reviewing of applications, EACCME has set a three-week rule, which is supposed to apply to both Sections/Boards/ESABs and NAAs. As stated before, Sections/Boards are not paid if they need more than three weeks to assess an application.
With regard to NAAs, several UEMS documents stipulate that, should they fail to reply within three weeks, EACCME is authorised to award European accreditation. With respect to this rule, it is interesting to note that both 2003 and 2004 EACCME annual reports mention that:

*In the present year the EACCME has needed to use this provision not infrequently.*

Due to the frequent delays observed in 2005, it is not clear whether this rule still applies. This apparent lack of responsiveness could have several explanations. It could be that some NAAs do not have the necessary structure to perform a quick and efficient evaluation; that they are not interested at all in the concept of European accreditation; or that they do not see the need to review the application because a professional and unbiased evaluation has already been performed by a specialised Section/Board/ESAB.

**5.2.2.2 Suggestion**

Now that the system is established and those involved have gained experience, a deadline of four to six weeks for the whole process seems reasonable and achievable, provided that applications are processed in a professional and efficient way (i.e. electronically instead of manually). In its role as an umbrella organisation, EACCME should set clear rules and ensure that these are respected. It should be able to guarantee this deadline to providers.

**5.2.3 European Credits**

**5.2.3.1 Current**

As mentioned before, EACCME has introduced the ECMECs (European CME Credits), where 1 credit = 1 hour of education. EACCME has also set a rule according to which NO event can be awarded more than 3 ECMECs for ½ day and 6 ECMECs for 1 day of education. This system of 1 credit = 1 hour of education is transparent and easy to follow.

However, some countries apply neither the 1 credit = 1 hour of education rule, nor the principle of "no more than 6 hours of education per day".

Therefore, the numbers of credits issued by a NAA and by EACCME frequently differ and the provider receives a notification mentioning two different numbers of credits. This causes confusion and undermines the credibility of the system. Further, there is no document stating exactly the value of one credit in each country, thus making comparisons very difficult, for instance for doctors about to move to another country.

**5.2.3.2 Suggestion**

Some European Universities and Medical Schools, have developed a European Credit Transfer System (ECTS) which gives a common definition of the number of hours a student should spend on learning activities to earn 1 credit (throughout Europe, a Bachelor's degree corresponds to 180 credits and a Master's degree to 120 credits). In order for the European CME credit system to gain more
transparency, a common standard should thus be agreed by all participating countries. Only then will it be a real "European" system.

5.2.4 Quality assurance criteria: non-biased education:

UEMS document 9908: Providers have to guarantee that non-biased education is given.

Industry-presented education must be clearly distinguished from CME activities under the control and supervision of the provider’s CME planning committee. Standard uniform terminology should be used to identify industry-presented education which should not be scheduled to compete with CME activities.

5.2.4.1 Current

NAAs and Sections/Boards/ESABs are asked to assess the programme before the event takes place to try to find out whether it is biased. Programmes which seem to be biased should not be accredited.

However, there is currently no clear guidance on the definition of "non-biased education" in particular with respect to the accreditation of CME events organised / sponsored by pharmaceutical companies (e.g. evening symposia at international congresses or other symposia organised by the industry). From the above, it would seem that educational events organised by the industry should not be granted accreditation at all. However, in a recent interview to the www.seronosymposia.org Newsletter, B.Maillet, UEMS General Secretary, was much less clear-cut, specifying only that:

"The system is again very easy: one ECMEC per hour of activity with a maximum of 3 for half day and 6 for a full day activity. There are no additional credits for activities organized the same day such as Satellites."³

This seems to imply that although Satellite symposia cannot be granted additional accreditation, they could be part of the 6 credits per day a doctor can claim. The fact that, according to the www.seronosymposia.org website, all symposia organised by SERONO are CME accredited by EACCME seems to confirm this interpretation.

Another statement, which was published in the IPCAA (International Pharmaceutical Congress Advisory Association) Newsletter in August 2006 leads to the same conclusion:

Dr Bernard Maillet […] gave one of two "Educational Sessions" at the General Assembly. […] The main points raised were:
- Having taken a pragmatic view on the participation of Industry in Healthcare congresses, UEMS/EACCME are no longer opposed to sponsored symposia provided the science is of high quality and is presented without bias
- A detailed costing (on a sliding scale dependant upon number of anticipated attendees) of applications for CME was shown and discussed, as was a flow chart (with timings) of activities for application for CME recognition.⁴ ⁵

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³ Newsletter available at: http://www.seronosymposia.org
⁴ Newsletter available at: http://www.ipcaa.org/bulletin.asp
Some specialties automatically refuse to accredit any events organised by the industry, while others have much more flexible rules. There have also been a few cases where the EACCME central office has accredited an industry event without previously referring to the appropriate UEMS Section/Board/ESAB. Needless to say, these inconsistencies only lead to confusion and discontentment among both the pharmaceutical companies and the relevant accreditation bodies. Moreover, the lack of clear guidelines from EACCME makes it very difficult for everyone to perform efficiently. For instance, no communication has been issued with respect to the EACCME change of policy related to the accreditation of evening symposia (see above), although a brief look at the EACCME list of accredited events has confirmed that the EACCME Central Office has already implemented this change. Increasing confusion even more, to our knowledge, those symposia have been accredited based on the assessment by a NAA only without review by a Section/Board/ESAB).

ERS Annual Congress, Munich  
**Advances in the Therapy of PAH**, supported by Schering AG

10th EFNS Congress, Glasgow  
**Restless Legs Syndrome: Dopamine Agonists in Practice**, supported by Boehringer Ingelheim

ESICM 19th Annual Congress  
**Advanced Bleeding Care: Improving Clinical Outcomes in Trauma and Intracerebral Haemorrhage**, supported by Novo Nordisk

International Conference on Surgical Infections, 6 – 8 September 2006, Stockholm  
**Serious Gram-positive Infections – The Big Issue**, symposium supported by CHIRON

5.2.4.2 Suggestion

It is crucial that EACCME sets up clear guidelines as to the circumstances under which events or other CME activities sponsored or organised by the industry may be accredited. Those guidelines should be disseminated to all stakeholders (UEMS Sections/Boards/ESABs, NAAs, pharmaceutical companies etc). As an umbrella organisation, EACCME should be responsible both for setting up guidelines and for ensuring that they are enforced uniformly across specialties.

5 It should be noted that the EACCME proposal to grant accreditation to satellite symposia but without increasing the number of daily credits awarded to one event to more than six raises many questions. First: would they automatically be accredited as being part of a congress? Or would they have to apply individually (i.e. each pharmaceutical company)? Second: if the latter solution applies, then it would mean that there would be multiple invoices for the same credits (since a scientific congress can already receive the maximum of 6 credits per day, credits attributed to the satellite would already be included in these 6 credits per day), but would be invoiced again to each company organising an evening symposium at the scientific congress. Third: to whom should a doctor attending such a symposium apply to receive their credits? To the scientific society organising the congress or to the pharmaceutical company organising the symposium?

5.2.5 Quality assurance criteria: attendance control

UEMS Document 9908: ...providers of CME should only be accredited if they address themselves to this point...

5.2.5.1 Current

Many providers have not yet implemented efficient attendance control methods (at least for large congresses), but up to now, no questions have been asked by the EACCME central office. In the past six years, no further guidance has been issued on this subject.

5.2.5.2 Suggestion

Some scientific societies have already implemented attendance control procedures for large events. Conclusions should be thus drawn from their experience, and a pilot project could start before issuing clear guidelines which would apply to all.

5.2.6 Quality assurance criteria: post-event reports from providers

UEMS document 9908: Providers of internationally accredited CME activities should submit a short report of each CME activity to the EACCME. Apart from the personal data of foreign participants, information including the programme, the development of the CME activity and the actual attendance should be reported.

5.2.6.1 Current

Some Sections/Boards/ESABs do ask for such a report. However, they represent a small minority. As for EACCME itself, it does not request these reports.

5.2.6.2 Suggestion

Using the online platform to be created for applications, a function could be developed for online post-event reports to be completed by all providers.

5.2.7 Quality assurance criteria: feed-back from participants

UEMS document 9908: Arrangements should be made to facilitate feedback concerning the learning process from the participants to the provider of the CME activity. Evaluation of this information should be available to the EACCME if requested.
### 5.2.7.1 Current

EACCME asks for a copy of the feed-back questionnaire to be distributed. Some Sections/Boards/ESABs ask for a post-event evaluation of these questionnaires, or even for copies of the participants' answers. However, EACCME itself has never requested this information.

### 5.2.7.2 Suggestion

Still using the online platform, create a standard online feedback form to be completed by all participants (who could be contacted by email by the provider after the event). Participants should only receive their CME credits if they complete the feedback form. A statistical tool would automatically aggregate the answers and feedback reports would be made available both to the provider and to EACCME. Using such a central tool in a de-centralised way would allow providers to interact with their participants, while allowing Sections/Boards/ESABs as well as EACCME central office to keep an accurate track-record of providers' performances.

### 5.2.8 Quality assurance criteria: self-assessment

**UEMS document 9908**: Self-assessment is necessary, both for the provider and for the participant. Mechanisms for this purpose should be present.

#### 5.2.8.1 Current

Not all providers offer self-assessment possibilities for all their events. For example, large congresses very often offer no opportunity for self-assessment. In contrast, e-learning modules and CME journals automatically offer self-assessment opportunities to participants. Paradoxically however, the latter are not accredited by EACCME whose activities are restricted to live events.

#### 5.2.8.2 Suggestion

Each educational item whether it is included in a live event or part of a distance learning module ideally should be accompanied by a self-assessment test supplied by the provider. For live events, the test may be available at the site of the educational activity or may be supplied by the provider by post or electronically on receipt of a request for a CME certificate by a participant. The answers to the questions may be supplied at the same time or may be retained by the provider who undertakes to mark the test papers and supply a certificate if a satisfactory level of knowledge has been reached. For distance learning (web-based), the test may be incorporated in the module and the participant may have to answer the questions correctly before being allowed to continue.
5.2.9 Accreditation of e-learning, enduring materials, CME journals etc.

5.2.9.1 Current

As mentioned previously, even though the need to find a solution to accredit these activities has been identified for five years, EACCME has still not proposed any practical solution to address the issue.

However, in the past few years, European scientific societies, which are the main CME providers of independent CME education at European level, have invested time, energy and money in developing user-friendly, high-quality educational materials, either online or through their publications.

It should be noted that these materials enjoy an increasing popularity among doctors, since they make CME less expensive and more flexible when compared with live events. A study performed by a scientific society on 150 European doctors revealed that, given the choice, they would prefer to perform around two thirds of their CME education online, provided that their time and effort would be rewarded by appropriate CME credits.

It is clear that the double-reviewing process currently performed for live events (through NAAs and UEMS Sections/Boards/ESABs) is not suitable for international journals, e-learning activities etc. which have by definition no nationality, since they are prepared by international teams for an international audience studying from home. Currently, since EACCME has not implemented any procedure to accredit such activities at European level, the only solution for providers is to apply separately to 30 different NAAs, thus creating a huge administrative workload and massive multiplication of the same tasks. Since such activities are clearly going to increase in the future, this problem requires urgent attention.

5.2.9.2 Suggestion

For these activities, the relevant UEMS Section/Board/ESAB should be mandated to perform an accurate and unbiased assessment of the activity, and NAAs should then accept the decision made by the competent UEMS Section/Board/ESAB. It should be noted that, contrary to live events, those activities can be evaluated beforehand, thus allowing for a very accurate assessment.

5.2.10 Provider versus event accreditation

5.2.10.1 Current

The present European system requires that each event be assessed individually. The same was true in the United States until a few years ago. With the number of requests for accreditation in the USA steadily increasing, it was felt at a certain stage that provider accreditation would be much more practicable and efficient, and this led to a complete reform of the system. Instead of assessing individual events, providers of educational material were rigorously evaluated and if considered satisfactory, were given a licence to continue their activities for a specified period of time.
In Europe, the increasing number of providers seeking accreditation for their events, and the need to accredit e-learning activities, CME journals etc. may also lead to an overheating of the system within a couple of years. For specialties which accredit many events, it may become more difficult to find reviewers who are prepared to devote the time necessary to assess activities on an honorary basis. In particular assessment of e-learning activities will prove very time-consuming.

Well aware of this situation, a few specialties have been looking into the possibility of moving towards provider accreditation. A few have even started to accredit some providers, such as national scientific societies. However, at present, it seems that most specialties are still content to deal with case-by-case event accreditation.

5.2.10.2 Suggestion

The expected increase in the number of accredited events over the next 5 years, as well as the consequences of starting to accredit e-learning activities, CME articles etc. on a case-by-case basis should be carefully assessed.

The experience of the specialties which have introduced procedures to accredit providers should be examined, and a pilot study could start within a few specialties, for specific categories of providers. The study should be limited in time (2 to 3 years) and a full report should be provided at the end of the pilot.

5.2.11 Mutual Recognition Agreements

5.2.11.1 Current

When it was first set up, EACCME made it clear that it did not mean to supersede any National Authorities, but would act solely as a clearing-house (UEMS Document 0217):

Right from the start of the EACCME it was clear that the national professional regulatory bodies could approve a structure making CME credits in Europe exchangeable, but only with the condition that they will remain firmly in charge of events in their own country and that they would have a decisive vote in the governing body of the EACCME. This is a political reality. In some countries it is based upon the expectation that within a few years mandatory recertification will occur and that CME credits will play an important role in this recertification.

The EACCME received its mandate from the national regulatory bodies, but with several distinct conditions:

The National Authority (see footnotes) should be maintained. The EACCME should not become a supranational body, but a link and clearing-house between the national regulatory bodies.

The final word concerning accreditation of each activity should thus rest with the national regulatory body in the country where the activity takes place.

The Brussels administration should be as lean as possible.

Quality assurance and determination of number of credits of separate CME activities should be decentralized. Here the EACCME should rely upon the expertise of professional bodies in each specialty such as the UEMS.
Sections/Boards and national/European professional societies, thus avoiding duplication of quality assurance proceedings.

The current system has always suffered from an unclear definition of EACCME's role as 'clearing house' of CME accreditation and of the UEMS Section/Board/ESAB's role in the accreditation process. Some NAAs have not been prepared to recognise credits granted by countries deemed "less mature" in the field of CME accreditation. The UEMS Specialty Sections/Boards/ESABs have thus been called upon to guarantee independent and high-quality evaluation. The downside of this system being of course that the whole workload is doubled (evaluations performed by both NAAs and UEMS Sections/Boards/ESABs) and conflicting assessment results may occur.

In an attempt to rationalise the system, EACCME has now drafted Mutual Recognition Agreements which have been proposed to both NAAs and UEMS Sections/Boards (but not to ESABs).

The Agreement with Sections/Boards sets the deadlines, fees and procedures to be followed for the quality evaluation to be performed by the UEMS Sections/Boards.

The Agreement also mentions that, should a Section/Board fail to perform its quality evaluation within 3 weeks, EACCME would have to find alternative expert advice. However, there is no mention on where and how this advice can be found. More generally, it is not clear whether EACCME applies any kind of quality control to the way in which the Section/Board performs its work. Finally, the Agreement concludes with the following paragraph:

This agreement on mutual recognition of credits between the UEMS – EACCME and the UEMS Section of ….. on the one part and the National Accreditation Authorities of the Member States of the European Union/EEA on the other part, aims to assist the National Accreditation Authorities in providing an objective European evaluation of CME events and thus reduce duplication of their workload. It should also help the National Accreditation Authorities recognise each other's work.

However, reading both Agreements (with NAAs and with Sections/Boards), it is not clear at all how duplication of the workload could be reduced / prevented under the current procedures which, as stated in the Mutual Agreement proposed to Sections/Boards, foresees that both evaluations must be performed simultaneously, meaning that NAAs cannot benefit from a previous expert evaluation by the Section/Board. It is also not clear how this agreement with the Sections/Boards could help NAAs recognise each other's work since there is no mention of European quality evaluation in the Agreement proposed to NAAs, which simply states the following:

Concerning the mutual recognition of CME credits, in view of the equivalence [NAA and EACCME] between the CME events accreditation systems used by both institutions, they mutually accept and recognise the CME credits granted by each one. This acceptance must comply with the rules of the attached protocol.

This therefore means that EACCME automatically validates the credits from countries which have signed the Agreement. This means that if country A and country B have both signed the Agreement,

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7 It should be noted however that this procedure is not always respected, and that both reviews are at times performed subsequently, the downside here being that it makes the whole process very long.
they automatically accept each other's credits through the EACCME automatic recognition. In that case, evaluation by the Sections/Boards becomes irrelevant. Mutual recognition therefore 'cements' national differences, e.g. concerning accreditation of industry-arranged CME or different maximum numbers of credits earnable per day. The flaws of multiple parallel systems operating in Europe are therefore not addressed by the new system.

Again, it is not clear whether EACCME applies any kind of quality control with respect to the way in which the NAA deals with accreditation. Hence the question: will all countries (signatories and non-signatories) be willing automatically to accept the credits awarded by signatory countries because EACCME automatically validates them? Or will a second expert evaluation from a Section/Board still be necessary?

5.2.11.2 Suggestion

From a general perspective, it is understandable and logical that NAAs want to keep control on what happens in their country and on the quality of activities followed by their doctors. On the other hand, they should also realise that the main European scientific societies do not organise their events in one specific country to meet the needs of local doctors, but rather because the congress centre and city infrastructure are suitable. Therefore, in some cases, there are less than five percent attendees from the host country, thus making national CME accreditation by the local NAA irrelevant for 95 percent of the audience. The same would apply to e-learning activities, CME journals etc. It should therefore be taken into account that for a whole category of providers, who invest time, money and energy in setting up high-quality CME, national accreditation is much less important than harmonised European accreditation recognised across both countries and specialties, since doctors may attend events organised by different organisations working in affiliated fields.

As such, mutual recognition agreements are helpful because they establish a framework for the relationships between the different stakeholders of the system. However, the time has undoubtedly come to simplify the whole system, to stop doubling all the work, and to make the process more transparent and user-friendly.

To prevent the system from being crushed under its own weight, it is now crucial to start efficient collaboration instead of repeating the same tasks and procedures at different levels in the system (EACCME itself, NAAs and Sections/Boards/ESABs).

Mutual recognition agreements should thus encompass the following:

Agreement between EACCME and Section/Board/ESAB:

The Section/Board/ESAB recognises the authority of EACCME as an umbrella organisation setting the framework of the European accreditation system (rules for quality criteria, value of credits, time-frames for evaluations, licensing Sections/Boards/ESABs, etc).

EACCME recognises the competence of the Section/Board/ESAB to assess international activities and entrusts it with the task of accrediting these activities according to the rules it has set. It does not interfere with or over-rule the Section/Board/ESAB decisions.
Agreement between EACCME and NAA:

The NAAs recognise the authority of EACCME as an umbrella organisation responsible for the ground-rules of the European accreditation system. They accept that, through its Sections/Boards/ESABs, EACCME is competent to perform independent and unbiased evaluations of international CME activities according to transparent rules. It is expected that it will be easier for an individual NAA to recognise accreditation by EACCME/Section/Board/ESAB than by another NAA with perhaps different evaluation criteria.

EACCME recognises the competence of the NAAs to assess all national events taking place in their home countries. It recognises that the NAAs are free to set the rules for their own doctors (status of CME, number of credits to be earned each year). In the evaluation process of international CME activities, NAAs collaborate with the relevant Section/Board/ESAB. They could for instance provide feedback on local speakers, or perform a site visit.

5.2.12 Sections/Boards vs ESABs vs Boards outside UEMS

5.2.12.1 Current

As mentioned previously, each specialty has a different structure to deal with CME accreditation. Originally, EACCME intended to work with the UEMS Sections in the assessment of submitted events with the Secretary of the Section functioning as the contact person. Some specialties, which had already set up UEMS Boards, which were responsible for education and training matters, devolved CME accreditation to them. Finally, aware of the workload that this new activity would involve, and of the importance of a well-developed CME accreditation system, some specialties decided to form new entities specifically to deal with CME accreditation. These new entities called European Specialty Accreditation Boards (ESABs) are joint ventures between the UEMS Section and the corresponding European scientific society. In parallel, some specialties such as haematology which are not recognised by the UEMS and do not have their own sections have also developed independent CME accreditation structures. It should be noted that because of their professionalism, even though they function outside of the EACCME system, they do not seem to encounter any problems with respect to the recognition of their credits throughout Europe.

The main strength of Sections/Boards and ESABs is that they combine the statutory authority of the UEMS/EACCME through their section with the scientific, professional and administrative expertise of their European society. Further, the alliance with the relevant European society allows the Section/Board and ESAB to gain access to a large panel of reviewers in each area of the specialty's interests.
5.2.12.2 Suggestion

With time, all specialties should set up a Board dealing specifically with accreditation matters, to ensure that educational activities for which accreditation is sought are assessed by a team of motivated experts who are willing to spend the time necessary to assess the quality of the activities.

As an umbrella organisation, it is the role of EACCME to encourage the creation of such Boards and to ascertain that they have the resources (human, technical and financial) to perform the necessary quality assessments in acceptable conditions. These conditions could be achieved through: setting a minimum number of reviewers, providing a user-friendly platform for processing applications online, and encouraging regular meetings of Board members etc.

EACCME should aim to license only those Accreditation Boards which work according to a set of previously defined criteria. EACCME should monitor the activities of the Boards to ensure adherence to its rules.

5.2.13 Structure of EACCME

5.2.13.1 Current

Through its Advisory Council, EACCME has a forum where all the main stakeholders involved in European CME accreditation are represented. However the potential benefit of this asset is not fully realised because EACCME is not managed by representatives elected by the Advisory Council, but instead by the same people who manage the UEMS.

The fact that the Advisory Council meets only once a year and has no decisional power means that European CME accreditation is not led and managed by its main stakeholders (and thus experts), but by a group of people who might have different interests, priorities and areas of expertise.

Similarly, within the UEMS central office, there is no staff member entirely dedicated to European CME accreditation.

5.2.13.2 Suggestion

Due to the rapidly increasing importance of European CME accreditation, a more professional system should be introduced, operated by people with expertise in this field of activity. More specifically EACCME should be reformed with inclusion of the main stakeholders as full partners with decisional power.

The principal stakeholders would be:

- NAAs
- UEMS Sections/Boards
- ESABs
- CME providers
- Post-graduate medical school faculties
If this suggestion were to be accepted, the stakeholders could elect from their number an executive and office-bearers.

### 5.2.14 Finances

#### 5.2.14.1 Current

As mentioned previously, EACCME invoices providers for each accredited event (see also section 2.2.3). Since 2001, the number of accredited activities has rapidly increased, and the introduction of a sliding scale in 2003 (a flat fee of EUR 100 had been used in the years 2001 and 2002) led to an increase in EACCME revenues:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of accredited activities</th>
<th>Revenue in Euros*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>104</td>
<td>10,400</td>
</tr>
<tr>
<td>2002</td>
<td>198</td>
<td>19,800</td>
</tr>
<tr>
<td>2003</td>
<td>364</td>
<td>61,943</td>
</tr>
<tr>
<td>2004</td>
<td>431</td>
<td>73,344</td>
</tr>
<tr>
<td>2005</td>
<td>604</td>
<td>102,784</td>
</tr>
</tbody>
</table>

*Figures for 2003 and 2004 were not available. The figures above are therefore rough estimates based on the sliding scale used in 2005.
These figures include only the amounts paid to EACCME directly, not those paid to Sections/Boards or NAAs.

It is interesting to notice that EACCME Annual reports 2001 and 2002 both state that:

Annual income has covered the expenses and EACCME can now be separated from the UEMS budget completely. The main expenses have been for meetings and travelling.

However, in spite of repeated requests, a specific budget for EACCME could never be obtained. While the number of accredited events has increased by 600%, EACCME revenues have increased by 1,000% and it is important to ascertain how this money is being re-invested into the system, taken into account the fact that:

- there has been no investment in IT systems;
- travel fees to the annual meeting of the Advisory Council are paid for by each participant;
- EACCME does not issue any written documentation/publications etc.;
- at least some of the EACCME central office business-related travel is sponsored by the pharmaceutical industry.

5.2.14.2 Suggestion

In order for the system to become more transparent, it is proposed that the EACCME budget should be separate from the UEMS budget, and that a yearly financial report should be published and disseminated to all stakeholders.

Should a proposal for a more collaborative system be approved (e.g.: common internet platform), it is clear that IT costs will be increased. On the other hand, some costs which currently are paid by the Sections/Boards/ESABs which have developed their own IT platforms might be cut. In any case, the objective would be to allow each and every specialty, whether large or small, wealthy or not, to have access to the same system in order to ensure common quality standards. It is therefore proposed that each specialty would contribute to the costs of the system on a pro rata basis according to the use it makes of the system (i.e. number of applications processed for example) and to the magnitude of its educational activities. Initially it might be necessary for specialty accreditation boards to apply to their respective European Scientific Societies for financial support.

6 Conclusion

As underlined all along this report, the central role of UEMS/EACCME in first setting up, and then maintaining a system for European CME accreditation is not and should not be questioned.

However, as shown by the information collected to draft this report, the system which was set up in 1999 has in many ways not developed as expected and has not acquired a more mature and established status. Since the entire medical world is convinced that CME will play a major role in the professional life of tomorrow's doctors – whichever country they come from – it is our firm belief that
the time has now come to dedicate adequate resources to allow this embryonic European CME accreditation system to evolve successfully.

We are of course aware that any such fruitful evolution will require minor concessions from all stakeholders. However, bearing in mind that the ultimate aim of the system should be to serve the interests of all European doctors and, through them, those of their patients, such concessions should not represent an insurmountable obstacle.

In summary, we are convinced that a range of practical measures could be implemented which would allow us to restore the full credibility of the current system:

- Treat all stakeholders as equal partners within EACCME (NAAs, UEMS Sections/Boards/ESABs, CME providers, post-graduate medical school faculties);
- Encourage the creation of an ESAB in each specialty;
- Update, clarify and disseminate the recommendations issued in 1999 (D9908) to all relevant parties;
- Develop a common internet platform allowing for harmonized, transparent and rapid treatment of all applications;
- Give the EACCME central office the means to monitor efficiently the enforcement of recommendations and to maintain the above mentioned internet platform;
- Devolve the responsibility of all operational aspects of the accreditation process to NAAs and Sections/Boards/ESABs in a collaborative approach;
- Look forward and keep an open mind with regard to the accreditation of e-learning activities, journals and any other educational materials which will be developed in the future;
- Monitor effects of different modalities of CME on clinical behaviour and patient outcomes;
- Re-invest the money that flows into EACCME further to improve and validate the system;
- Reinforce links with the European Union to make our efforts known and try to obtain EU funding to finance further developments.

Having drafted this report, it is now our hope that it will serve as a basis for discussion on the future development of the European CME accreditation system.

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8 For example, over the summer, the EU issued a call for proposal entitled: "Call for proposals EAC/33/06 - Award of grants for the promotion and coordination of projects to develop Credit Systems for Vocational Education and Training (ECVET)", which would have perfectly matched our aims and objectives.