CONTINUING MEDICAL EDUCATION WITHIN EUROPE – MODELS FOR THE FUTURE

Proposals for discussion by CME group in Oslo

BACKGROUND:

In order to be more effective and focussed we have decided to set up a core group of paediatricians who have a very significant interest and expertise in CME and the members of this subgroup are as follows:

Martti Siimes (Secretary)

Wilhelm Sedlak

Marion Crouchman

Peter Hoyer

Helmut Helwig (exofficio chairperson)

Arne Host

Juan Brines

Michael Weindling

Eva Olah

Alf Nicholson (Chairperson)

Following our deliberations in Evora , Portugal in May 2000 a number of recommendations were made and these can be summarized as follows:

1. **The CME working group should develop further the framework set out in the CME Charter published in 1998**

2. **Electronic recording of CME activity is the way forward and incentives are required to promote successful recording of CME . Voluntary recording alone will not succeed**

3. **CME sessions at international meetings should be interactive and small group case discussions are very popular amongst paediatricians**

4. **The professional development plan has the potential to be used outside the UK and serves as a good model**

5. **The development of a European Academy of Paediatrics similar to the American Academy of Paediatrics is a longterm desirable aspiration**

6. **The role of CESP is as a facilitator for CME within Europe**

Taking on board the above summary of recommendations and using documentation from the UEMS website , the American Academy of Paediatrics and other sources , we should propose two models for the development of CME within Europe . The proposal is that one may as a country adopt either model depending on the stage of development one is at . The models are termed :

A. Basic model for CME

B. Advanced model for CME

We wish to highlight in full both models and propose that , if acceptable , individual countries and paediatric associations adopt and amend either model depending on their particular stage of development.
It is also proposed that one would ,in time, naturally progress from the basic model to the advanced one . It is important to stress that these are only templates and it is felt that national associations will amend and adjust these models to suit their own needs and circumstances

A. BASIC MODEL FOR CME :

1. Mission statement:

' Leadership and Learning are indispensable to each other'

Medical education should be a lifelong and never-ending process

2. Basic constituents and their individual functions:

(a)Relevant medical/paediatric association:

This system may operate on a regional/state or national basis and is the responsible authority for setting appropriate CME targets for individual paediatricians . Most national authorities set a target of at least 50 hours per year . Paediatricians are required to identify educational activities as clinical , academic and professional.. At least 80% of activities should be in the clinical category . There should be an equal split between internal (those carried out with colleagues within one's own institution / practice) and external (those carried out outside one's own institution/practice).
Recording of CME activity is voluntary and the relevant medical/paediatric association should set out a CME record book that is simple to follow and the individual paediatrician should send back their CME credit details to the relevant association on a yearly basis . An audit of returns must be kept and targets for completed returns must be revised upwards on an annual basis . Each association must have a chairperson who is responsible for CME and who oversees these returns . Targets for completed returns should be modest on year 1 (20%) but

should rise to > 80% by year 5 of the successful implementation of the programme. Random audits of individual padiatrician CME credits (whether returned or not) should be conducted and these should be presented , on an anonymous basis ,to the board of the national/state/regional association for discussion.

(*b) National/international meetings:*

All meetings should have a pre-meeting validation system whereby a set number of CME credits is assigned to the meeting and the content of the meeting and meeting programme is sent out in advance to the CME chairperson of the relevant association who then issues the number of credits that the meeting is recognised for. All meetings require an attendance list to be kept and all require to clearly display to participants the number of CME credits per session of the meeting . All meetingsshould include a meeting/ session evaluation record and a resume of this evaluation should be sent by the meeting organizer to the CME chairperson . The issue of sponsorship by pharmaceutical companies is a difficult one and the CME credits issued are always at the discretion of the CME chairperson . National scientific meetings should try to incorporate specific CME sessions with small group discussion and active audience participation

(c) *European Accreditation Council for CME:*

The EACCME was established in 1999 to coordinate reciprocal accreditation of CME activities in Europe. The growing integration of Europe and the right to free movement between countries necessitates European coordination and EACCME fulfils that purpose. The EACCME will not provide accreditation of CME activities directly but will connectexisting and emerging eccreditation systems in Europe and will act as a clearing house for accreditation of CME in Europe. It does not superced the national auhority on accreditation of CME. UEMS/EACCME criteria for quality of CME should be developed to emphasise the following :

1. **members of the target audience should be on the planning committee for meetings**

2. **learning objectives should be derived by needs assessment**

3. **evidence-based methods should be employed**

4. **the opportunity for participants to receive feedback on their learning should be built in**

5. **technical back up should be of a very high quality**

(d)*PREP programme*:

Following excellent work by Helmut Helwig and others , the American Academy of Paediartics PREP programme has been made available at lower cost to CESP members and paediatricians throughout Europe. Uptake to date has been variable but there is a definite role for this programme in aiding CME within Europe

SUMMARY:

Under the guidance and supervision of the national /regional paediatric society , the above 4 components are the cornerstone of a successful CME process which can be built upon if one wishes to progress to the advanced CME model

B. ADVANCED MODEL FOR CME:

Mission statement:

Paediatrics is global and paediatric education should be also . Leadership and learning go hand in hand and the ability to change is the essence of leadership.

Continuous lifelong learning has always been a feature of effective medical practice. In this advanced model the term CONTINUING PROFESSIONAL DEVELOPMENT (CPD) is used and the intention is to help paediatricians to maintain standards , interest and enthusiasm in their practice , to protect their skills and professional competence and to develop new skills in accordance with changing medical practice

This advanced model for CPD or CME is intended to be practical , flexible and realistic.

For advanced CME the essential elements include :

(a) Relevant medical/paediatric association:

Validation and monitoring of the CME/CPD process is the responsibility of the relevant medical/paediatric association External CME usually requires study leave in protected time and includes organized meetings and courses and personal visits to outside institutions to acquire new skills. Internal CME includes unit clinical meetings , multidisciplinary meetings , grand rounds , community education sessions and clinical audit meetings.

The relevant medical/paediaric association should specify that:

(1) the basic unit of CME will be one hour

(2) The target will be 50 hours per year

(3) One whole study day will normally be allocated 6 credits in educational timewith a maximum of seven credits if evening sessions are included

(4) Half day sessions will be allocated three credits

(5) At least 50% of credits will come from external CME with the remainder from internal CME

(6) The CME certification period will be five years from entry into the cycle

(7) Attendance at international events will be considered individually by the CME subcommittee and prior authorization from the CME office is required

(8) Doctors in part-time employment/job-sharing arrangements need to fulfill the same CME requirements as those in fulltime employment

(9) A CME record will be sent to each paediatrician and details relating to all internal and external CME activities attended should be entered in this CME record and this should be retained by the individual paediatrician with 3 monthly postcards sent to the relevant medical/paediatric association indicating CME credits obtained

(10) Monitoring of CME will be via a random review of the CME records on an annual basis. This will require that the individual paediatrician selected will be required to send in additional documents to verify activities attended

(11) Participating paediatricians may request an annual summary statement of their CME credits

(12) A list of those who have fulfilled the CME requirements will be maintined by the relevant medical/paediatric association

(13) Satisfactory completion of a 5 year cycle will earn a CME certificate

(14) Participation in the CME scheme is necessary if a paediatrician is to be deemed to be ' in good standing' and non-participation shouls exclude a paediartician from being an office holder in the association or from being an examiner

(15) Issues such as paediatricians working in geographically isolated areas , those with an inadequate study budget and those with increased domestic commitments need to be explored by the relevant medical/paediatric association

(b) Personal portfolio-based learning:

This is a process whereby one keep a record of less formalized learning and this may be tabulated in a REFCECTIVE NOTES format which would describe a clinical experience and detail how this experience highlighted any further learning needs. The participant can claim a maximum of 5 credits per year via this process. Small group discussions and shared experiences with a clinical practice review format are extremely useful and may be aided by a telemedicine link in areas of geographical isolation

(c) *Online CME 'Home'*:

This is again adapted from the American Academy of Paediatrics and is based on the PREP programme and it allows paediatricians design their own CME programme and gain individual feedback from the system. It starts with a subjective needs assessment and there is then a response with some recommendations.
The site is customized to each user and is endlessly revisable. Updates on CME requirements occur automatically and are availabe to each user. This system is in operation in the USA and has been very successful.

SUMMARY:

The advanced CME model brings in an element of validation of CME returns by the relevant medical/peadiatric association and also entails the personal learning experience (either portfolio-based or created via CME on line 'home') and the term continuing professional development. Both systems require funding and commitment by the relevant paediatric association to succeed.

AJ Nicholson May 2001