Journal of European CME
The Open-Access Journal on CME-CPD Practice

European CME Forum
www.europeanCMEforum.eu

informa healthcare

J Euro CME, Volume 2: 5–9, 2013
ISSN: 2161-4083

DOI: 10.3109/21614083.2013.772056

ORIGINAL RESEARCH

Beyond accreditation systems – the identification of different implementation models for CME across Europe

Madeleine Schaffer[1] **and Ina Weisshardt**[2]

[1]EIMSED, Vienna, Austria

[2]White Cube Consultants, Munich, Germany

Abstract

We have previously published the results of a comprehensive research project which was conducted in 11 European countries in 2010/2011 to establish a detailed database on the implementation of CME in these countries, including underlying structures, roles and responsibilities, and funding models. Special attention was given to the role of the various stakeholders such as Ministry of Health/government, physician associations/societies/chambers, and universities in addition to the positioning of CME within the medical education pathway from undergraduate through postgraduate to life-long learning. We showed that there were three models for the implementation and accreditation of CME: physician-centric model, politician-centric model and university-centric model. In this paper we describe a more detailed analysis of these systems. The three different types are characterised by different leaderships (physician representations, Ministry of Health and universities), different drivers and different means of access to CME. There was no relationship between the accreditation system implemented in the respective country and the identified CME implementation model. In addition, different approaches to funding were identified for the different models, from purely governmental funding to predominantly third party sponsoring, revealing different risks for bias in the different models. We conclude that knowledge of the underlying model may be crucial for providers of medical education and medical societies when executing international educational programmes for their members or setting up international collaborations. It is hoped that these new findings may also stimulate an interesting discussion amongst the leaders in CME on what may be the future model for CME in Europe: Is there one compelling model other countries may want to follow?

Keywords: European implementation models for CME, comprehensive research project, beyond accreditation systems, future model for CME in Europe

Introduction

Over the last decade CME stakeholders successfully focused their efforts on the harmonisation of CME across Europe, leading to similar credit-based regulatory systems in various countries.[1–3] According to UEMS, 19 countries have implemented a credit-based CME system and 18 countries have made participation in certified CME activities mandatory.[2,3] But do comparable accreditation systems imply a single CME system for the region? The objective was to ensure consistent quality for CME activities, distinct separation between promotional education and CME, as well as more

Correspondence: Mrs. Madeleine Schaffer Mag., EIMSED, Rotenturmstrasse 27/6, Vienna, 1010 Austria. E-mail: M.Schaffer@eimsed.com

History
Received: 20 December 2012
Accepted: 29 January 2013
Published online: 19 March 2013

Table 1. Overview of CME models and responding countries.

	Model 1: Physician-centric	Model 2: Politician-centric	Model 3: University-centric
Credit-based, mandatory	Germany, Italy, Switzerland, Austria, Czech Republic	France	Hungary
Credit-based, voluntary	UK (CME activities)	Spain	Ukraine, Belarus
Non-credit-based, mandatory	UK (revalidation)	–	–
Non-credit-based, voluntary	–	–	–

transparency for physicians when choosing CME activities. CME providers have directed their attention to the different national requirements and have sought to comply with these national and regional requirements. CME alliances and related CME congresses have provided knowledge about these requirements. Further attention is still necessary for the implementation of these different accreditation requirements between the respective countries and the potential implications for CME providers, societies and congresses.

In October 2010, a pan-European field research project covering 11 countries was initiated by EIMSED and implemented between October 2010 and October 2011 in cooperation with White Cube Consultants providing a unique database on three main aspects of national medical education systems including undergraduate, postgraduate and continuing medical education: i) terminology and understanding, ii) accreditation systems and iii) the medical education path.[1]

A subanalysis of the database revealed significant differences between the countries in their approach to the implementation of CME, especially in terms of roles, responsibilities and funding. It was found that there were three models for the implementation and accreditation of CME; physician-centric model, politician-centric model and university-centric model. The aim of this paper was to examine these different models in greater detail.

Research methodology

As part of the analysis, the study team reviewed the data on the different implementation models for CME and their relationship with the prevailing accreditation system. Therefore, countries were clustered based on the following criteria:

1. Roles and responsibilities: Who is in the driver's seat for CME? Who takes decisions? Who provides the regulatory framework?
2. Position of CME within the medical education pathway
3. Funding models

Results

The first cluster of countries, named Model 1 or physician-centric model, is characterised by the leadership of physician chambers/associations for CME. In the second cluster, named Model 2 or politician-centric model, the responsibility for CME lies within the Ministry of Health, while in the third cluster of countries, Model 3 or university-centric model, universities are the responsible authority for the implementation of CME. Interestingly these findings are independent of the accreditation system and very much driven by the historical political environment (see Table 1).

The different implementation models are given as follows:

Model 1: The physician-centric model (see Table 2, 3)

In the physician-centric model the responsibility for CME is given to the official physician organisations of the respective countries. Physicians are directly responsible for the development of the regulatory framework for CME as well as for the approval of educational activities.

In this model the government (e.g. the Ministry of Health) plays only a minor role in CME – in some countries the provision of the legal framework stays within the Ministry of Health. Universities have no defined role in the general management of CME apart from the possibility of providing CME and/or becoming an accredited CME provider. The delivery of CME activities in this model is clearly separated from the medical educational pathway and is provided by various stakeholder groups which may include medical education companies, pharmaceutical companies, individual physicians, hospitals, universities, physician associations and national scientific societies.

Overall this model can be characterised by a rather unstructured approach to CME activities where the

Table 2. Physician-centric model overview of countries and CME authorities.

Country	Regulatory framework	Management of CME activities	Approval of CME activities/providers
Austria	Austrian Medical Chamber[a]	Austrian Medical Chamber	Austrian Medical Chamber
Czech Republic	Czech Ministry of Health	Czech Medical Chamber	Czech Medical Chamber
Germany	German Medical Chamber	Regional Medical Chamber	Regional Medical Chambers
Italy	Ministerio des Salud	Regional Medical Chamber	Regional Medical Chambers
Switzerland	Swiss Medical Association	Swiss Medical Association/specialty societies	Swiss Medical Association/specialty societies
UK	General Medical Council	Royal Medical Colleges	Royal Medical Colleges

[a]The authors consciously refer to the national medical associations as "chambers" (verbatim translation of the German term "Kammer") as it originates from the traditional chamber system in the respective countries.

Table 3. Physician-centric model overview on stakeholder involvement.

	Role and responsibility	Impact on CME
Universities	• Responsibility limited to undergraduate education • Teaching hospitals in postgraduate education • No structural or regulatory involvement in CME • Local CME providers	Low
Medical associations/ chambers	• Provision of regulatory framework for CME • Tracking of compliance according to regulations • Certification of educational events • Accreditation of CME providers	High
Specialty societies	• (Accredited) CME providers	Medium
Sick funds	• (Seldom) Funding of CME activities	Low
Pharmaceutical companies	• Funding/Sponsoring of CME activities • Influence on which therapeutic areas are covered by CME	High
Physicians	• Participation in CME	Medium
Government/Ministry of Health	• Overseeing body • Cooperation with National Medical Chambers • (Seldom) Funding of CME activities	Low/ Medium

Table 5. Politician-centric model overview on stakeholder involvement.

	Role and responsibility	Impact on CME
Universities	• Responsibility limited to undergraduate education • Teaching hospitals in postgraduate education • No structural or regulatory involvement in CME • Local CME providers	Low
Medical associations/ chambers	• Certification of educational events • Accreditation of CME providers • Regional CME providers	Medium
Specialty societies	• (Accredited) CME providers	Medium
Sickness funds	• (Seldom) Funding of CME activities	Low
Pharmaceutical companies	• Funding/Sponsoring/ Implementation of CME activities	Medium–High
Physicians	• Participation in CME	Medium
Government /Ministry of Health and its bodies	• Regulatory framework • Provision of funding (tax) • Certification of educational events • Accreditation of providers	High

physician can independently choose activities in which to participate. A curriculum-based approach is uncommon in this model. Funding of CME in this model is provided by third parties, with pharmaceutical companies being the primary source of funding, complemented by co-payments from the learners. Governmental contributions are very low to non-existent.

Typical representatives of this model are Germany, Austria, Italy and the Czech Republic. The UK and Switzerland also follow this model, but with some significant differences and will therefore be paid separate attention.

In Germany, Austria, Switzerland and the Czech Republic, the National Medical Chambers are the key stakeholders for the management of CME including the provision of the regulatory framework through Code of Conduct and additional regulations as well as tracking of compliance with the framework. The Medical Chambers are also responsible for the certification of educational events and the accreditation of providers (where applicable). Physician associations and specialty societies do not have a direct role in the management of the CME framework but may become accredited providers.

In Italy the Regional Medical Chambers have been the key stakeholders for the management of CME including the implementation of the regulatory framework, while the Ministry of Health provides the regulatory framework. A trend towards a more centralised approach for CME through the Ministry of Health (Model 2, see below) has been identified.

In Switzerland and the UK, the specialty societies/ Royal Medical Colleges are the key stakeholders for the delivery of CME. Physicians in Switzerland have to participate and complete the educational curriculum of the

Table 4. Politician-centric model overview of countries and CME authorities.

Country	Regulatory framework	Management of CME activities	Approval of CME activities
Spain	Ministerio de la Sanidad	SEAFORMEC (Body of the Ministry of Health)	SEAFORMEC/Regional Medical Chambers
France	Haute Autorité de Santé	Conseil Scientific Indépendent (Body of the Ministry of Health)	Conseil Scientific Indépendent/ Regional Medical Chambers*
Italy**	Ministerio del salud	Regional Medical Chamber	Ministerio del Salud/ Regional Medical Chambers

*System is still in transition and subject to change.
**Special case comprising both Model 1 and Model 2.

Table 6. University-centric model overview of countries and CME authorities.

Country	Regulatory framework	Management of CME activities	Approval of CME activities
Ukraine	Ministry of Health	Universities	Ministry of Health*
Belarus	Ministry of Health	Universities	Ministry of Health*
Hungary	Ministry of Health	Universities/ESZTB (Commission for professional education and continuing education in the health care system)	Universities**/ ESZTB

*No approval of activities but universities have to be accredited prior to providing educational measures.
**Third-party providers have to be validated by a university.

Table 7. University-centric model overview on stakeholder involvement.

	Role and responsibility	Impact on CME
Universities	• Provision of learning continuum from undergraduate, postgraduate to continuing medical education • Provision of learning curriculum for CME • (Single) CME provider • Validation of CME providers (if applicable) • Tracking of compliance with regulations	High
Medical associations/ chambers	• Responsible for ethical aspects	Low
Sickness funds	• (Seldom) Funding of CME activities	Low
Pharmaceutical companies	?	?
Physicians	• Participation in CME	Low
Government/Ministry of Health	• Regulatory framework • Tracking of compliance	High

specialist society relevant to their current professional occupation.

Model 2: The politician-centric model (see Table 4, 5)

In the politician-centric model, the Ministry of Health is the centrally responsible authority for the organisation and management of CME. The involvement of Medical Chambers/Associations is limited to the accreditation of programmes. CME is implemented independently and clearly separated from the university system or governmental structures by various third parties.

Spain is a typical representative for this model with the SEAFORMEC (Sistema Español de Acreditación de la Formación Médica Continuada), a body of the Ministry of Health being the central anchor point for organisation, management and accreditation of CME activities. In addition, the Regional Medical Chambers may provide, coordinate and approve regional CME activities. Providers of CME activities include professional medical associations, physician associations and medical education companies. Pharmaceutical companies may provide sponsorship but may not appear as providers of an educational company.

France (and partly Italy) has only recently moved from a physician-centric approach, with the regional physician chambers being responsible for the organisation of CME, to a politician-centric model under the responsibility of the Ministry of Health. CME in France is publically financed, and since 2012, the distribution of funds is coordinated by the governmental body OGC (L'Organisme de Gestion Conventionelle). It is partly financed by tax income from the pharmaceutical industry. Additional budget comes from a mandatory contribution of self-employed physicians, managed by the central union of physicians.

National Medical Chambers only play a minor role for CME in this model with the primary responsibility for defining and supervising the Code of Conduct for physicians. Regional Medical Chambers may be involved as providers of CME or in the accreditation process. Unlike any other European country, pharmaceutical companies in France may directly organise and implement CME activities.

Model 3: The university-centric model (see Table 6, 7)

The university-centric model is characterised by a centralised, structured CME system, closely embedded in the medical education pathway from undergraduate to postgraduate education with the universities being the dominant providers of CME while the legal framework is provided by the Ministry of Health. Universities play the central role in the implementation of educational measures for undergraduate, postgraduate and continuing medical education. The Ministry of Health is the central body, providing the legal framework, structures, regulations and approvals. Universities have to be accredited by the Ministry of Health before providing educational measures.

The direct implementation of CME measures by third parties, such as medical education companies, plays a minor role in the university-centric model – collaborations do already exist as well as the possibility of validation of third parties by universities. In general, funding of CME activities is provided by the government. The role of the pharmaceutical industry on funding of CME activities remains yet to be defined, since no detailed information was received as part of the research project.

Typical representatives for this model are Ukraine and Belarus. Also, Hungary has been allocated to this cluster with a structured educational system, integrating undergraduate, postgraduate and continuing medical education. Universities play a central role in the implementation of educational measures, but unlike

Table 8. Strength and weaknesses of the different models.

	Strength/Opportunities	Weakness/Risks
Model 1	• Freedom of choice for the learner • Flexibility • Continuing development and improvement of CME opportunities due to numerous providers	• Lack of curriculum • Strong dependence on commercial sponsors • High risk for commercial bias • Low involvement of universities as experts in education • Unstructured approach • Self-management of education
Model 2	• Independent funding • More structured approach	• Lack of a continuum • No structural involvement of universities as experts in education • Slower development due to low number of CME providers
Model 3	• Structured, curriculum-based approach • Continuum of learning and provider (university) from undergraduate to postgraduate	• High risk for governmental bias • Lack of funds

Ukraine and Belarus, other providers may also implement educational measures on condition that they have been validated by a university. The Hungarian ministry of health is the centrally responsible authority for professional education and continuing education in the health care system. Unlike the physicians in Ukraine and Belarus, physicians in Hungary must fund their CME activities themselves.

Discussion

The identification of three different CME implementation models across Europe, independent of the accreditation systems, generates two important questions:

1. What are the strengths and weaknesses of the three systems?
2. Is one model superior to the others?

In countries following Model 1, CME is driven by physicians' associations/chambers. The number of stakeholder groups is very high, and there is no central responsibility. Universities play only a minor role in the CME community, and perhaps for that reason, no structures for the development and implementation of CME can be found. Since there is no continuum from under/postgraduate training to CME and there is a lack of central structures, setting up curriculum-based CME will be extremely challenging. Since governmental involvement is very limited, funding only comes from third parties leading to a strong dependency on commercial sponsors and to a high risk of commercial bias.

The main difference of Model 2 as compared to Model 1 is the much greater independence in terms of funding that may reduce the risk of commercial bias, but may at the same time lead to limitation of available funds. As for Model 1, the lack of a continuum in education and very limited involvement of universities in CME also pertain.

For Model 3, funding of CME is guaranteed through university structures and the close embedding within the governmental educational system. Therefore, the risk of commercial bias is very low but the risk of governmental bias is clearly increased as compared to those of Models 1 and 2 (see Table 8).

Conclusions

This research project analysed and identified for the first time the existence of different European CME implementation models, which reflect the historical and political structures of the country and the related cultural background. Due to the limitations of the research project, no correlation could be established between any of the identified implementation models and the quality of CME in the respective countries. Based on the current knowledge, no superiority of one model versus the others could be found – each model has its own strengths and weaknesses. Knowledge and understanding of the different models have two important implications for the European CME community. We need to go beyond accreditation systems and firstly be aware of the existence of these different CME implementation models when planning educational projects in order to reach the learners and to meet their needs. Second, we must take a closer look at the different models when defining our vision for CME. Diversity in models is not necessarily a sign of a lack of maturity for CME in the region but it derives from the political and cultural background of Europe. Working together on a country-by-country level or on a cluster-level may help to identify what works and what does not work under the respective implementation models and ultimately may help either to improve the current model or to develop the ideal model for the implementation of CME in Europe and beyond!

Declaration of Interest

Funding

This study was funded by EIMSED.

Author(s) Financial Disclosure

I.W. has disclosed that she is a consultant/advisor for EIMSED.

M.S. has disclosed that she has no relevant financial relationships.

Peer reviewers

Peer Reviewer 1 has disclosed that he has no relevant financial relationships.

Peer Reviewer 2 has disclosed that he has no relevant financial relationships.

References

1. Weisshardt I, Schaffer M. Increased understanding of medical education pathways in Europe. J Euro CME, Early Online: 9–17; 2012.
2. Harvey L. CME/CPD in Europe – update 2011, EACCME/UEMS Conference, Brussels, November 2011.
3. Maillet B. The EACCME system. EACCME/UEMS Conference, Brussels, November 2011.