14th Annual GAME Presentation Highlights
Lyon, France
June 7-9, 2009

With interest in improving the understanding of best practices in global CME and inviting increased participation by CME providers, the Global Alliance for Medical Education (GAME) is pleased to present abstracts and highlights of its 2009 Annual Conference held in Lyon, France. Complete slide presentations are available on the GAME web site www.game-cme.org.

Robert F. Orsetti, MA, CCMEP, FACME, Editor

Dear All,

The GAME committee would like to thank everyone who helped prepare our 14th meeting this year and all those attendees whose presence was indispensable to our understanding of the current global CME community. The general consensus of the meeting was positive and we will continue to strive to improve the program to address the core issues of Global Best Practices in CME. Attendance continues to increase and the diversity of our audience is adding an element of perspective that enriches our global understanding. We encourage all GAME members to visit the new website at www.game-cme.org, to stay informed of the latest developments in CME, but also to refer to as a content resource tool. The following 2009 GAME summary includes the main highlights of the event and gives you a snapshot of all the slide presentations available on the GAME website.

GAME’s new president, Paul Piché, BSc, MBA, and our entire board look forward to welcoming you in 2010 for our 15th Annual Meeting in Montréal.

Sincerely,

Hervé Maisonneuve, 2007-2009 GAME President
Welcome and Keynote Address, Sunday June 7th - Grand Réfectoire, Hotel Dieu

For more on Richard’s ideas on the evolving role of medical journals, refer to his book “The Trouble with Medical Journals.”

CORE ARGUMENT: “If you agree with Yeats then journals play an important role in education. They aren’t good at “filling pails,” making coherent change happen,” but they can light fires and prompt debate.”

Smith explained during his presentation what he felt journals were for, the main points were:

- Informing
- Reforming
- Disseminating science
- Educating

“Education is not the filling of a pail, but the lighting of a fire.” W B Yeats
Ron Murray, CME Office, University of Virginia, Charlottesville, USA

Ron Murray, GAME Secretary, presented on “Global Best Practices: What are your needs?”

Key points of presentation:
• Changing Times, CPD versus CME
• Adopt a CME Strategy
  • Planning
  • Implementation
  • Evaluation
  • Improvement
• Needs Assessment as a foundation for effective educational planning
• CME process versus QI cycle
• Needs based CME should be designed to achieve an outcome to improve:
  • Performance
  • Competence
  • Patient outcome

Jann Balmer, CME Office, University of Virginia, President of Alliance for CME

Jann Balmer spoke about the “Practical Pearls for Globalization in CME/CPD.”

Sharing various suggestions on web-based CME, the following points were identified:
• User patterns
• Challenges in Design and Implementation
• System Considerations

A few web-based CME Pearls…
• Create options where users can access all of the answers to questions in a non-threatening manner
• See opportunities to connect the local environment
• Create multiple formats that can be accessed by wireless or smart phone technologies
• Create and track critical thinking/analysis and knowledge translation into practice
• More clearly define the scope, framework and expected outcomes for specific or groups of activities

LISA SULLIVAN, IN VIVO COMMUNICATIONS, CROSS BORDER EXPERIENCES IN DEVELOPING CME/CPD IN SOUTHEAST ASIA AND AUSTRALIA

Lisa Sullivan gave the audience at GAME an eye-opening look into the challenges facing a homogenous CME system in South East Asia (SEA) and Australia. Some of the shortfalls of CME/CPD in SEA are:
• Australia and NZ are well versed in interactive learning and patient centered models
• SE Asia learning is based on didactic presentations with little interaction or reflection for the “student”
• Case based learning is almost non-existent in Asian CME apart from Australia/NZ
• Most countries do not entertain CPD other than Hong Kong (still focused on knowledge and skills education alone)

What is needed?
• Commercial providers
• Discussion groups across countries where English is common
• Acceptance of CPD from “accredited” external countries
• Changing formats to include needs analyses/interactivity/reflection of learning

JOHN MARLOW, ADVANSTAR COMMUNICATIONS

“Private and Academic Collaboration for optimizing patient care.”

Collaborate (Merriam-Webster):
Etymology: Late Latin collaboratus, past participle of collaborare to labor together, from Latin com- + laborare to labor

1. to work jointly with others or together especially in an intellectual endeavor
2. to cooperate with or willingly assist an enemy of one’s country and especially an occupying force
3. to cooperate with an agency or instrumentality with which one is not immediately connected

CME Model: Reform is in process
Solution: Collaboration, Self regulation, Measurable difference
Challenge: Overcoming barriers to collaborate among the three organizational cultures and groups

Figure 1. Collaboration Groups
• What tribe do you belong to?
• What category do you fit into among the three collaboration groups?
  Commercial primary social model: Military
  Academia primary social model: Priesthood
  Professional primary social model: the crafts guild

DENNIS WENTZ, WENTZMILLER & ASSOCIATES
Mission:
• to create a standard of certification for the men and women who develop, deliver, or support educational programs for practicing physicians and other healthcare professionals.
• to acknowledge, evaluate, and reward individuals for their achievements in the field of continuing medical education.

BERNARD MAILLET, SECRETARY GENERAL, UEMS
Raising an interesting topic for debate, Dr. Maillet asks the question, “Do we need MECCs in Europe?
Pros versus Cons of Medical Education Communications Companies

Table 1. Do We Need Certified People?

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<td><strong>Pro</strong></td>
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<td>Aware of rules and regulations</td>
<td>Commercialisation of the process</td>
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<td>Competent in their field</td>
<td>Risk to introduce bias</td>
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Figure 2. The Certification Model.

BERNARD GAY, COLLÈGE NATIONAL DES GÉNÉRALISTES ENSEIGNANTS
“How EURACT provides and oversees CME/CPD programs in multiple countries? “
The aim of the European Academy of Teachers in General Practice is to foster and maintain high standards of care in European general practice by promoting general practice as a discipline by learning and teaching.

DOUG KLEIN, UNIVERSITY OF ALBERTA
“International Medical Graduates, Transition and how it influences CME: A Canadian perspective”

“Give us 2 weeks, we’ll give you a career.”

PUSH PULL THEORY OF IMG’s in CANADA:
Physicians trained in countries without economic capacity to employ them were subject to a migration “push” from that country and a corresponding “pull” from countries with an economic capacity will lose these physicians to the latter country.
• IMG have specific learning needs which help them adjust to work in a new setting
• Support IMG physicians – CME, Mentorship
• Support IMGs personal transitions

Figure 4. Reprinted with permission of GAME.

FELIX VARTANIAN, RUSSIAN ACADEMY OF ADVANCED MEDICAL STUDIES, MOSCOW
During his overview of “CME in Russia: Development of International Collaboration,” Dr. Vartanian explained that once every 5 years the 615,000 plus doctors must take a CME exam.
The Russian Academy of Advanced Medical Studies has been collaborating with the WHO since 1980.
The Ministry of Health and Social Development is the ultimate authority on all medical education activities.

Figure 3. www.uems.net.
PESACH SVHARTZMAN, BEN-GURION UNIVERSITY OF THE NEGEV, ISRAEL

“Cultural Competency Issues in Educational Programs”

CULTURE IMPACTS:
• Health belief
• Chronic disease
• Symptoms meaning
• Breaking bad news
• Truth telling etc.

Table 2.

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<th>Cultural competence versus Cultural awareness?</th>
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<tr>
<td>INPACT- Israel National Palliative Care Training</td>
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<td>Mobile Palliative Care Unit→ Bedouins in rural areas</td>
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WANG KUN, HAUYISHENG.COM LTD. (GOOD DOCTOR)

“Managing the effectiveness of Distance Learning, Experience from CME China”

An overview of China’s medical hierarchy and CME system was given by Wang Kun.

Impressive numbers indicate the medical staff in China:

- Total medical staff: 5,907,052
- Licensed doctors: 1,644,467
- LICENSED nurses: 1,543,257

Online learning is approved by the Chinese Ministry of Health.

Affordability of e-CME in China:
- Off-line CME: $120-200/person/year
- Online CME: $20/person/year

HANNU HALILA, DIRECTOR, EDUCATION AND RESEARCH, FINNISH MEDICAL ASSOCIATION

“How Nordic Countries Collaborate with other countries for exporting Nordic CME/CPD Activities.”

The CME processes of Denmark, Finland, Iceland, Norway and Sweden compared; the main challenges

- Based on a voluntary system
- No recertification for doctors
- Biggest challenges: insufficient funding and possibilities to participate in CME
- Funding from pharmaceutical industry possible but regulated by national rules, usually set up jointly by the industry and the medical profession

Fun Fact: Out of the 17,900 physicians in Finland 55% are female.

JOHANN WEIDRINGER, BAVARIAN CHAMBER OF PHYSICIANS

“Experience of Landers in Germany”

In Germany there are: 16 states, 17 medical chambers

State Medical Chambers are responsible for rendering CME credits for regional on-site meetings and for web-based training.

There is a CME-ID-# card that each health care professional must have to track CME record.

MARCO CAVALLO, DIREZIONE GENERALE SANITÀ, LOMBARDY REGION

Lombardy Region CPD program

Agreement 08/1/2007 between Health Ministry and Regions (not yet working):

- Provider Accreditation Lombardy Region CPD System
- Individual educational project
- Registration and certification of CME credits
- Conflict of interest regulation
- Learning types including distance learning and field learning

Figure 4.

Figure 5. Lombardy Region CPD System
SONDRA MOYLAN, AMERICAN ACADEMY OF CME AND LISA STEPHENS, IIR MIDDLE EAST
“Experience of programs in Middle East Countries”
**American Academy of CME enter into joint sponsorship with IIR Middle East
  Health Authority of Abu Dhabi (HAAD)
  Focus is on continuous improvement
  2007 – Set guidelines for development of CME activities
  • 50 hours of CME per year, 25 must be formal instruction
  • 10 hours of 25 must be in specialty
  Lack of education is identified as the underlying obstacle for development of CME in the future

PETER POSEL, QUAIME
“Can Innovation CME Technology plus state-of-the-art content be the right answer?”
  Pilot Project QUAIME: eLearning versus traditional learning methods in CME. Result: “The present study proves that medical continuing education via e-learning is more flexible, efficient, time saving and more successful than traditional learning formats.”
  (Prof. Dr. Peter A. Henning, Hochschule Karlsruhe, Institute for Computers in Education, Final report, QUAIME Pilot Project, 30.09.2008)

SAURABH JAIN, INEGENE LIFESYSTEM
“The Indian Experience”

KEY POINTS ABOUT CME IN INDIA
• No CME Accreditation system currently exists in India
• Performance improvement key for success in India
• Multinational Pharmaceutical companies are key funders for unbiased CME activity in country
• Support platforms are key for driving compliance for CME programs
• International content, Institute and Association add credibility to CME programs designed for Specialist

MAUREEN DOYLE-SCHARFF, PFIZER CME DIRECTOR
“Get the Facts” Campaign—A Public Affairs Campaign: Setting the Record Straight and Dispelling Misinformation about CME
  The National Task Force on CME established in 1989
  Task Force goals include the following:
  • To bring together individuals from a variety of CME perspectives
  • To propose mutually derived ethical solutions to issues in CME
  • To disseminate news and information regarding CME
  • To safeguard continuing provider/industry collaboration and support for CME
  • To review and recommend guidelines and regulations pertaining to the interface between CME providers and industry; and
  To provide educational activities that support our mission and goals.

INA WEISSHARDT, WHITE CUBE CONSULTANTS
“What Are the Relations Between Pharma Industry and the CME World in Europe: Is It Different From the US?”
  The US Way:
  • Increase regulations
  • Increase limitations
  • Change funding approach
  Summary
  • There exists no scientific evidence that commercial support creates bias
  • Bias is a potential issue with any party providing CME programs. Universities and CME providers can be just as similarly affected as the industry…
  • The detection of bias will only happen, if appropriate standards are defined and sufficient mechanisms are applied to provide fair balanced programs.

EUGENE POZNIAK, SIYEMI LEARNING
“Pharma supported CME in Europe: what does the future hold?”
  Key Points: Factors for success, companies in CME, future potential of CME activities in Europe, etc.

Figure 6.

Clustering Mechanics (Physicians and Specialists)
Current Practice Assessment versus Guidelines
  **Support platforms are essential for driving compliance for CME programs in India

Figure 7.
Table 3. Why does pharma in Europe not do CME?

- Loss of control
- No leading products in their field
- No perceived benefits

Three tiers of company types:

- Innovators
- Early adopters
- The rest

The “Big Scary Chasm”:

- A few companies have dipped their toe in the water
- No critical mass of companies as yet. Why?
- Pharma wants to do more, but remains unconvinced

BERNARD MAILLET, U.E.M.S.

“Are guidelines for commercial support of CME effective in Europe?”

Objective of Commercial Support Regulation:

To ensure the independence of CME/CPD activities by preventing the commercial bias

Conflict of interest (COI) is not bias but a “tendency” toward bias (M. Davis)

The main objective of Commercial Support’s Regulation is to ensure the independence of CME activities by preventing the commercial bias. These codes can be:

- National MDeon
- European EFPIA
- International IFPMA

Summary—CME without Industry support is nearly impossible* Industry ban is not the solution*Clear rules are much more effective

FIONA GODLEE, BMJ EDITOR

“Global CME/CPD in the worldwide economic crisis”

If there was one thing you should have remembered from Fiona Godlee’s presentation it is that, “Climate change is the most important health threat to the 21st century.”

Climate change may be a determining factor regarding new travel regulations for the industry, but will also change the epidemiology of infectious diseases.

The three key CME points discussed were

- What is CME?
- Who will pay for it?
- Will it work?

What is the “CME industrial complex”?

Economic Factors that will change CME:

- Economic collapse
- Pharma industry’s finances are drying up
- Restraints on industry funding

Preparing for Global CME 2010: Lessons learned and a call to action

Some of the following questions were raised during the concluding panel discussion.

1. Should doctors pay for CME?
2. Should an entity charge for their CME events to make a profit?
3. Why are some doctors seeking CME credits that may not even apply to them?
4. Why do some medical authorities change the CME regulations just to meet certain demands or issues?

CONCLUDING REMARKS

Networking was an important activity during the 2009 GAME meeting event that allowed all participants to share their respective CME experiences from Europe, North America, the Middle East and Asia. More than 22 different countries were present and delegates took home many important CME best practice messages. Developing an effective CME system requires a lot of effort and time, as we learned from the successes and pitfalls of our foreign representatives. The overall message is that our combined efforts to improve this system will benefit both practitioners and patients alike.

GAME would like to thank MedEd Global Solutions for preparing this meeting summary.

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