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# Report on Proceedings of the Thirteenth Annual European CME Forum, Held Virtually, November, 2020

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**ABSTRACT**

In common with many scheduled meetings in 2020, the Thirteenth Annual European CME Forum (#13ECF) was conducted between 4 and 6 November 2020 in a virtual format. Faculty and attendees from around the world interacted via plenary sessions, breakout workshops, panel discussions, question and answer sessions, and oral presentations from selected poster authors. The plenaries dealt with topical themes such as outcomes, collaboration, changes in educational activities due to digitisation, accreditation standards, and essential competencies for continuing professional development (CPD) providers. Breakout workshop themes included online and informal learning, a global approach to outcomes, interprofessional collaboration, the role of industry, patients as teachers, simulation, pathways to accreditation and adaptation to the virtual landscape. The Forum provided a comprehensive model of educational practice in the rapidly changing environment brought on by a pandemic.

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The 13th Annual European CME Forum (#13ECF) was scheduled to take place in Barcelona but, in common with many other meetings, was conducted online whilst still providing opportunities for interaction among attendees and the 70 faculty members. The theme for the Forum was **"European and global CME: What next?"** and the meeting had it all – barking dogs, tropical beach backdrops, show-off book displays, connectivity issues and temporarily muted presenters! Nevertheless, the attendees and faculty successfully overcame these minor drawbacks to participate in a comprehensive educational experience that covered many topical themes in the realm of CPD and the significant effect on all concerned due to the Covid-19 pandemic.

**Day 1** began with a review by Eugene Pozniak, the Forum Director, of key happenings in the world of CPD/CME that had taken place since #12ECF. Significant milestones were the move to virtual meetings, the article in the Journal of European CME (JECME) by Rodzinka et al. entitled "Regulating for Bias in Medical Education – Reaction to the Pharmaceutical Industry Updated EFPIA Code of Practice" [1] and the special collection of 12 papers in the Journal that focused on Outcomes in CME/CPD.

In an icebreaker test of the virtual platform that hosted the meeting, Chris Elmitt of Crystal Interactive and Lawrence Sherman set up table-top discussions among attendees to elicit topics of interest to be addressed during the forum. The main concerns that emerged focused on

- coping with the virtual environment,
- keeping engaged,
- how to upskill and reskill and
- how to mingle online.

Having used the meeting platform to interact, the focus for attendees then switched to the first plenary session where Robin Stevenson, the journal's editor-in-chief, and Don Moore, the guest editor described the realisation of the previously mentioned JECME special collection of articles. The dearth of submissions from medical societies was mentioned and all stakeholders were exhorted to consider providing articles for publication. Don Moore went on to conduct live interviews with the following authors to highlight points made in their articles.

a. Reinhard Griebenow

## Outcomes in CME/CPD – Special Collection: How to Make the "Pyramid" a Perpetuum Mobile

The main premise of this article was that CME should aim to improve both patient and community health.

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Barriers to the translation of physician competence into improvements in community health were highlighted and a continuum model of kick-off/keep-on medical competence was mooted. This model, as shown in Figure 1 integrates aspects of public health planning with delivery and outcomes measurement in CME.

a. Wendy Walsh ***CME in the Time of COVID-19: Educating Healthcare Professionals at the Point-of-care and Improving Performance Outcomes*** [3]

A global point-of-care clinical resource was described that allows users to obtain credits whilst researching clinical questions at the point-of-care and provide feedback on the answers obtained. The article explained how such access to information could affect clinical decision-making and lead to improvement in care related to COVID-19. The article suggested that benefits can accrue from self-directed, point-of-care CME on the clinical management of patients during a pandemic.

a. Lisa Sullivan ***Fostering Interprofessional Patient-centred Collaboration in Healthcare through CPD: Our Learnings from the PARTNER Programme*** [4]

This article reported on an interprofessional project in Australia involving specialists and primary care physicians dealing with the management of psoriasis and/or psoriatic arthritis. Increased levels of intent to collaborate and awareness of patient perspectives were reported. However minimal response to follow-up surveys limited the ability to directly measure actual changes in practice.

a. Jason Olivieri ***Effect Size Benchmarking for Internet-based Enduring CME Activities*** [5]

This article discussed a metric, called effect size, measured by Cohen's d which is used to indicate the standardised difference between two means. The authors looked at 40 accredited, Internet-based enduring materials produced between 2016 and 2018 and found that a Cohen's d between 0.48 and 0.75 might be considered a useful benchmark. They urged caution though in being too rigid in applying this benchmark given the fact that the reliability of available data from the CME arena may not yet be rigorous enough.

a. James Bannister ***Increased Educational Reach through a Microlearning Approach: Can Higher Participation Translate to Improved Outcomes*** [6]

This article reported on a comparison of activities defined as "microlearning", namely 15-minute case study clinics and podcasts, with more traditional e-learning activities. The microlearning programme was deemed to provide an increased reach to a target audience and produced a slight improvement in the number of completed evaluations but the degree of outcome evaluation was still limited. It was suggested that microlearning approaches should be combined with "micro-evaluation" such as posing a single, short question before and after a social media clip to provide more reliable measures of educational outcomes.

The complete set of articles and video interviews with authors can be accessed via the following JECME link: https://www.jecme.org/special-collection-2020

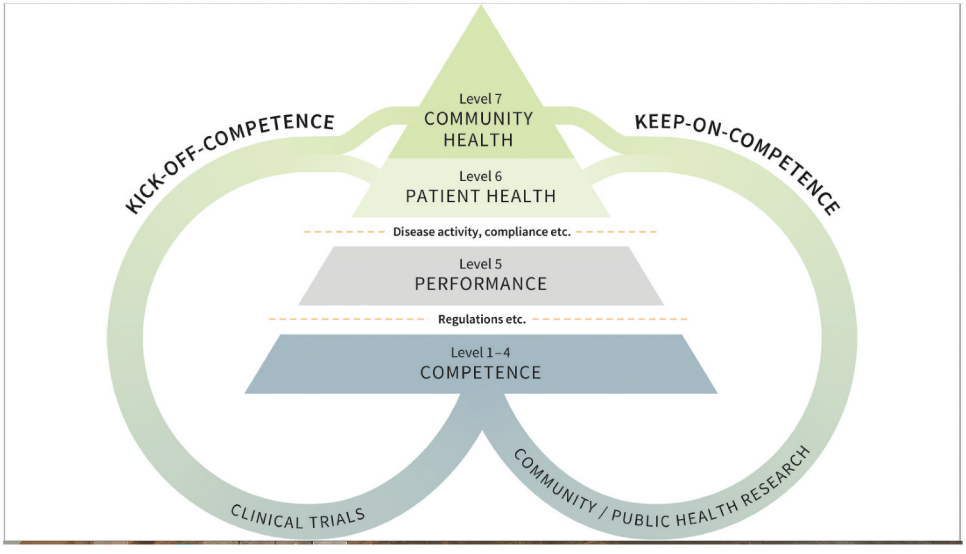


**Figure 1.** The "kick-off/keep-on continuum" of medical competence [2].

**Day 1** continued with three concurrent breakout workshops that were "pitched" via pre-recorded introductions to allow attendees to choose one to attend. The workshops presented were as follows.

## Workshop 1a. Identifying Factors for Success in Online Learning

Amy Farr from the European Respiratory Society and Jo Varney of Ogilvy Health Medical Education joined forces with Jane Wiedler and Miriam Uhlmann of the AO Education Institute to consider three aspects of online learning as outlined in their learning objectives shown in Figure 2.

Participants were charged with discussing and identifying ways of addressing the challenges posed in considering these three aspects and, in the reflection segment on the workshop, the following points were raised:

Instructional design

- a direct transposition of face-to-face activities to an online format is not recommended,
- robust planning procedures are needed for blended activities,
- consideration must be given to aspects, such as timing of sessions and breaks,
- harnessing technology and use of social media should be incorporated.

Faculty Training

- faculty may need pre-training and practice for presenting online,
- they need to be aware of how they appear in a virtual format and provide a "presence".

Assessment and Evaluation

- opportunities exist to improve online assessments to make them seamless and embedded within the educational content,
- providers should be encouraged to share best practices in design and implementation of assessment protocols.

**Workshop 1b**. CME/CPD outcomes in oncology: A global perspective

Ann Lichti, Janvi Sharma and Phil Talamo (Physicians Education Resource)

The format of this workshop was to provide case vignettes to the participants for discussion on challenges in being able to measure improvements in physicians' clinical performance and patient outcomes. The aspects under consideration that affect CME/CPD activity outcomes were:

- the clinical decision-making process,
- patients' goals of therapy,
- identifying optimal methods for assessing changes in clinical practice,
- collaboration with faculty to factor in clinical realities that affect outcomes.

On reflection after the workshop an adaptive learning approach was one of the main recommendations made that factors in the specific working environment of the learners with some further considerations shown in Figure 3.

**Workshop 1c – Digitising interprofessional collaboration**Julie-Lyn Nöel (EUROSPINE), Jamiu Busari (Maastricht University; Horacio Oduber Hospital), Margareta Nordin (EUROSPINE) and

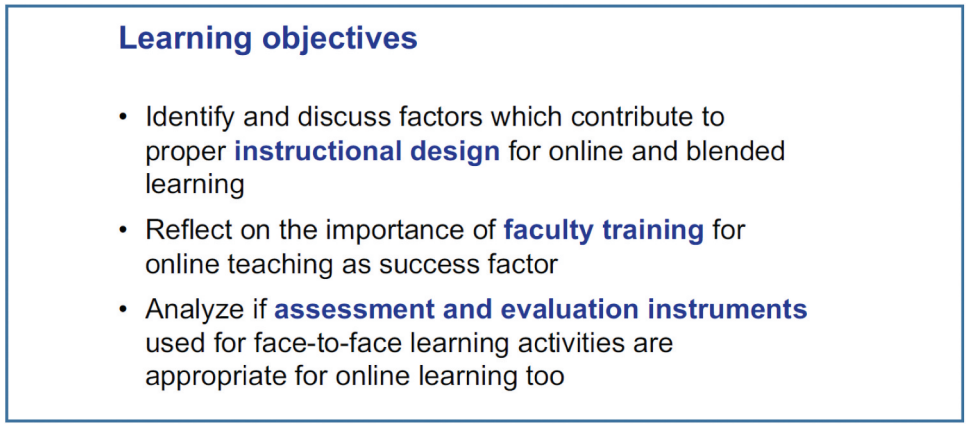


**Figure 2.** Learning objectives for Breakout workshop 1a [7].

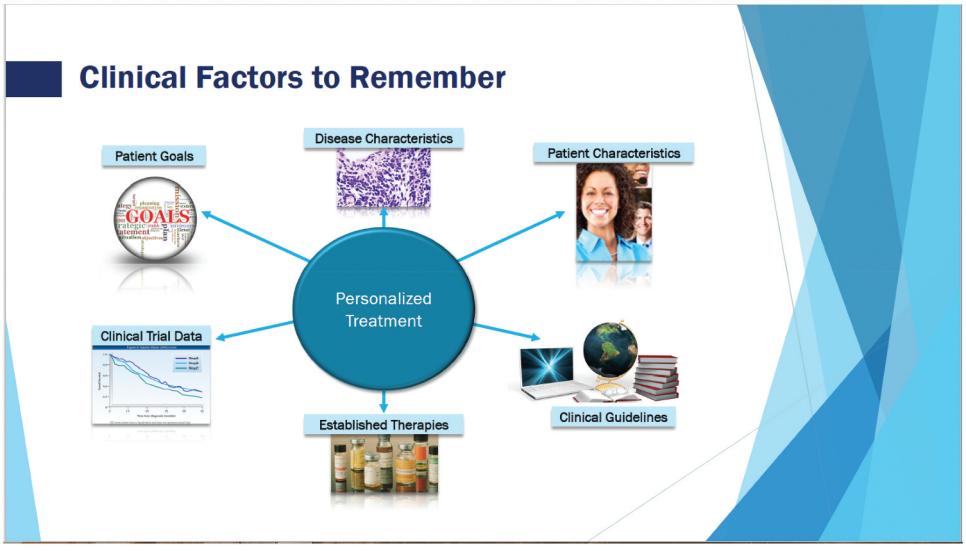


**Figure 3.** Factors to consider for patient and clinician outcomes in oncology [8].

Francisco Baptista (Francisco Serrano Baptista Consulting)

Based on the premise that healthcare professionals need be able to communicate and collaborate effectively in digital settings to aim for optimal healthcare, participants were challenged to identify the benefits and challenges of interprofessional collaboration in such settings. A case study was also provided in the form of a summary of the modules comprising the *Eurospine Diploma in Interprofessional Spine Care* (EDISC). Francisco Baptista also shared a framework for collaboration and a practical tool for implementing such a model. Figure 4 summarises the agreed benefits to be derived from applying interprofessional collaboration in the digital realm and Figure 5 illustrates Francisco Baptista's collaboration model and tool for effective communication.

## Plenary 2: Industry

**Evolving collaborations between medical societies and industry in the digitalisation of congresses** Eva Thalmann (Janssen; Chair, iPACME; Chair, EFPIA Working Group on Medical Education), Arthur Cannon (Roche), Dale Kummerle (GAME) and Christian-Claus Roth (Novartis)

The focus of this session was the rapidity of the switch that occurred in 2020 to move congresses run

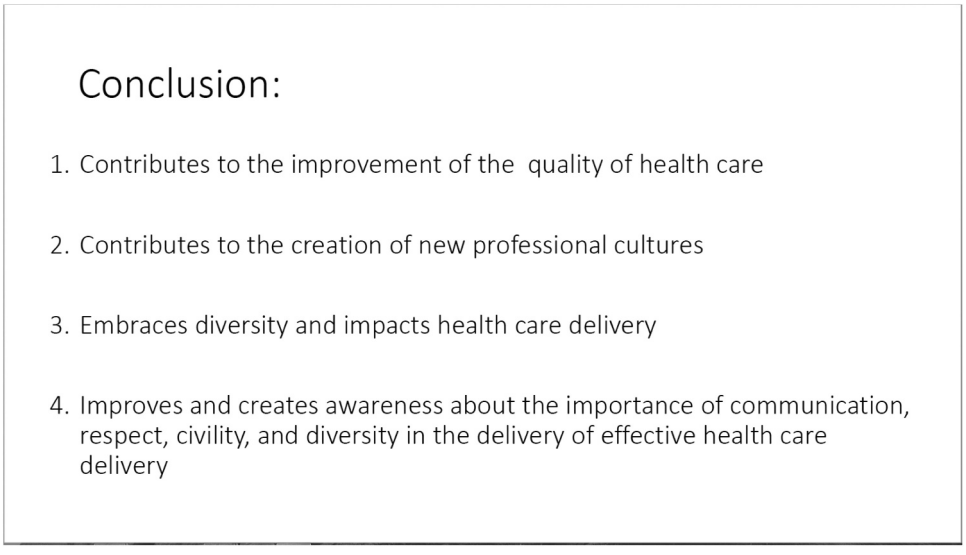


**Figure 4.** Benefits of interprofessional Collaboration [9].

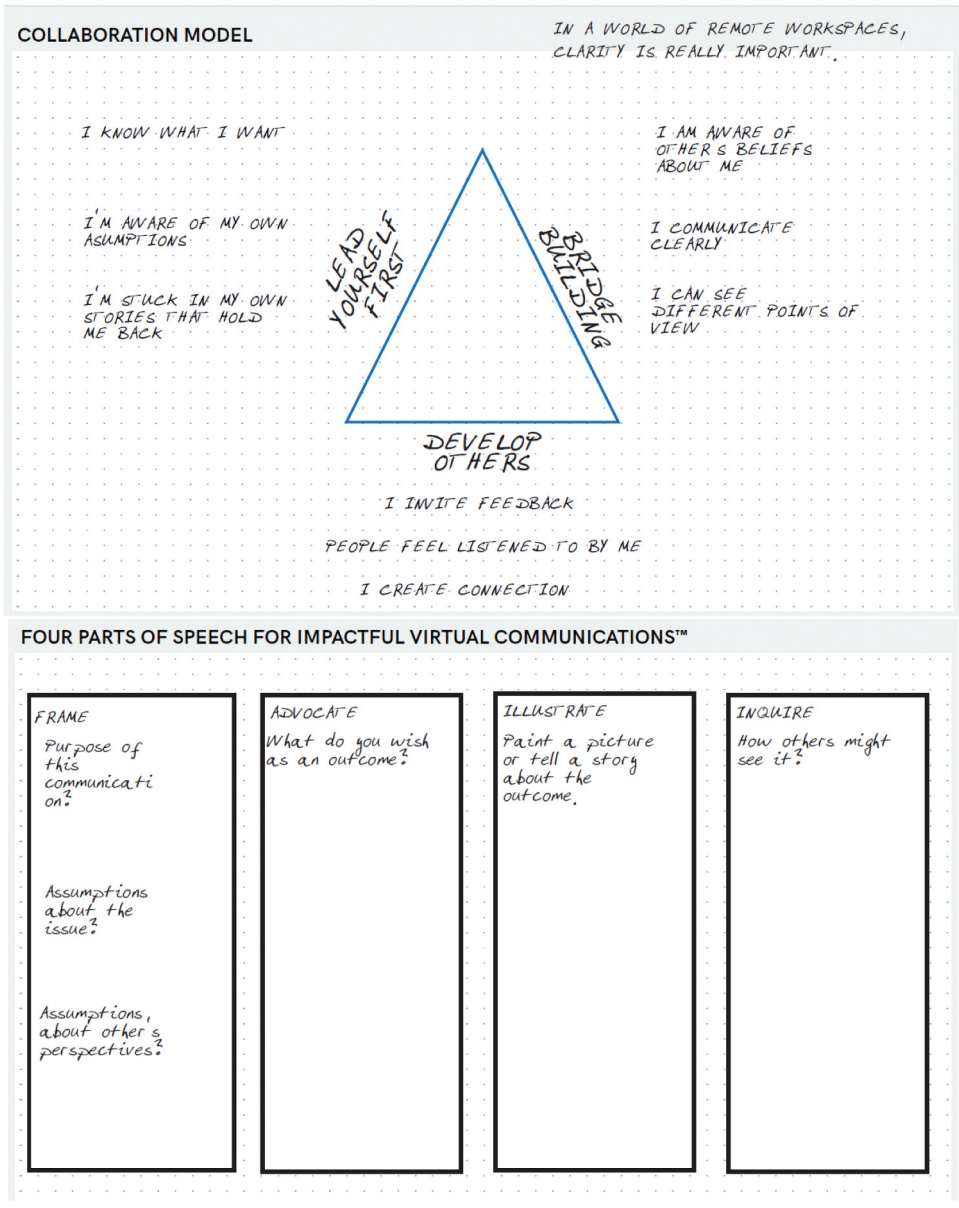


**Figure 5.** A model and tool for collaboration [9].

by medical societies to digital formats. These rapid changes required new collaborations and approaches among stakeholders. The presenters and participants discussed some of the challenges involved in the digitisation of congresses and there was a consensus that non-compromising collaborations between industry and societies were evolving to address these challenges. In comments on the near future for congresses it was suggested that hybrid-type activities may become the norm with anecdotal evidence emerging that remote working may have contributed to better productivity and a better work–life balance for many in the CME/CPD field. Other suggestions included the need for more interdisciplinary and interprofessional content in congresses and better alignment among industry organisations themselves. To some extent the latter suggestion may have been implemented by the fact that various industry bodies have collaborated to produce recommendations that address some of the issues raised. These recommendations can be accessed via the resource list that follows in Figure 6.

The next set of breakout workshops were as follows.

**2a – What does industry expect in good IME?** Pamela Mason (AstraZeneca), Patricia Jassak (Astellas) and Elizabeth Kelly (Eli Lilly)

Faculty members representing three different grantors for independent medical education discussed some of their expectations when considering grant applications from providers in the current climate of change associated with the Covid-19 pandemic. Some of these

**IFPMA/EFPIA/PhRMA resources on virtual congresses impacted by COVID-19**

Joint Guidance
https://www.ifpma.org/resource-centre/joint-guidance-on-virtual-international-medical congressesimpactedby-covid-19/

Webinar and other resources
https://www.ifpma.org/resource-centre/joint-guidance-virtual-international-medical-congresses-impacted-bycovid-19/

Case Studies
https://www.ifpma.org/wp-content/uploads/2020/09/Joint-Guidance-on-Virtual-International-Medical-Congresses-July-2020-Case-Study.pdf

Q&A Document
https://www.ifpma.org/wp-content/uploads/2020/09/Joint-Guidance-on-Virtual-International-Medical-Congresses-September-2020-QA.pdf

**Figure 6.** Industry recommendations for virtual congresses [10].

considerations are shown in Figure 7. Examples were given of successful activities that had utilised social media platforms, such as Twitter to provide short, sharp bursts of education to learners whose main tool for access is a smartphone. The concept of more personalisation of education related to parameters such as the age and workplace environment of learners was also discussed. The panel then engaged participants in a discussion of three key topics, namely:

- Inclusion and Diversity – how can medical education be more diverse and inclusive?
- Patients – how can medical education consistently include the voice of patients?
- Impact of COVID-19 – how will this change the medical education landscape in 2021?

The panel suggested that attempts to address health disparities are being looked at favourably in assessing grant requests and comments from the participants posited the idea that increased numbers of women becoming healthcare professionals could help to reduce disparity gaps. In addition, there was hope that attitudinal changes could see the patient voice more evident in CME/CPD activities. In common with other sessions in #13ECF an emerging theme was that evolving formats of educational activities might mean that more hybrid types of medical education may be part of the "new normal".

**2b – Importance of informal learning and how this has changed in a digital world**Jonas Nordquist

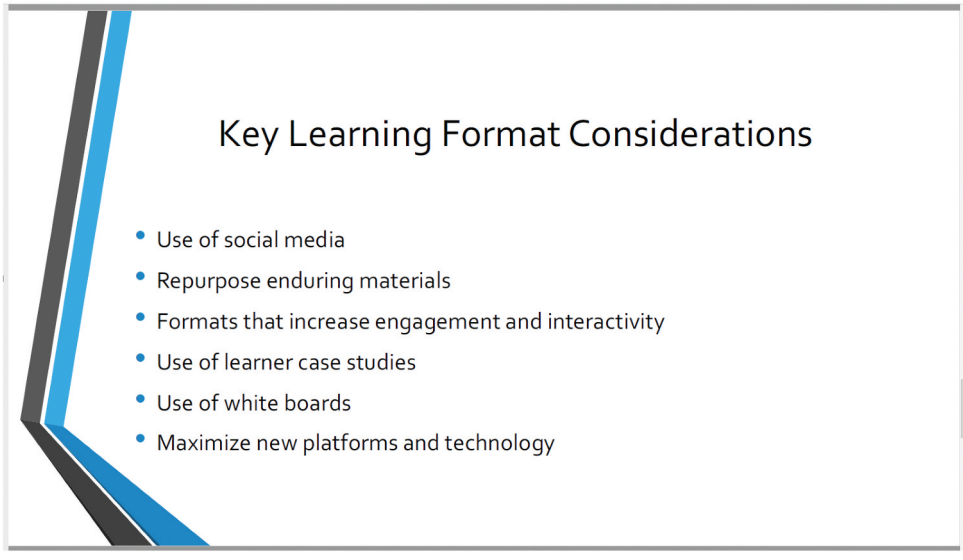


**Figure 7.** Evolution of educational formats being considered by grantors [11].

(Karolinska Institutet), Céline Carrera (EIT Health), Dean Jenkins (UCB) and Celeste Kolanko (Liberum IME)

It has long been considered that networking and informal learning are key components of educational activities. With the rapid move to digital formats for activities, the focus has tended to be on the formal sessions and seeking ways to make them interactive. This workshop considered the gap in addressing how informal learning can be maintained in the digital world. The spontaneity that comes from informal interactions has become difficult to achieve. The group put forward some ideas on best practices in the digital age, having first agreed that informal learning should be considered as a serendipitous process. Some examples of methods used to facilitate informal learning were as follows:

- informal spaces such as exhibition booths, "bars" and wine-tasting events,
- interaction with experts in virtual chat rooms and use of avatars,
- social media – links via hashtags to help visibility of participants.

The overall conclusion from this workshop was that much progress has been made in accommodating formal learning in the digital age but that gaps in the provision of informal learning still exist.

**2c – Why is industry involved in medical education and learning?** Damian Largier (Pfizer), Alesa Lehmann Ivancic (Merck, Sharp & Dohme) and Eugene Pozniak (European CME Forum)

This session allowed representatives of the main stakeholder groups in CME/CPD to review the involvement of the pharmaceutical industry in learning activities. It was acknowledged that, whilst the industry has access to a plethora of data and latest advances in therapeutic interventions and insights into some educational needs related to therapies, some see the involvement of industry as simply promotional. Eugene Pozniak provided a summary from a previous CME Forum presentation of the scope of medical education and the possible roles of industry as shown in Figure 8.

Participants were invited to provide opinions on an appropriate role for industry. In response to a polling question, the overwhelming consensus was that industry should have a role in education but with limitations and that a major factor in the scrutiny of such a role was the matter of trust. Some comparisons were made of the highly regulated CME/CPD situation in USA and that in Europe.

It was generally felt that, overall, a good relationship exists between industry and educational providers with standards being adhered to in accredited education. The most mentioned common ground was that of patient safety and the need to ensure that learners are fully aware of the interactions of industry and educators.

**Day 2** After a review of Session 2 breakout workshops the meeting continued with:

## Plenary 3: Medical Societies

**The role and shape of congresses in the digital age**David Vodušek (BioMed Alliance; EAN), Michel Ballieu (BioMed Alliance), Isabel Bardinet (ESC), João

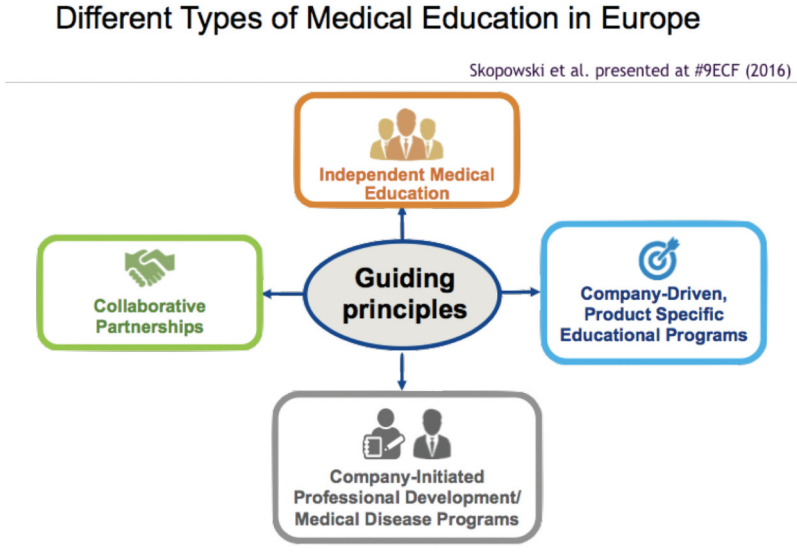


Figure 8. Possible roles for industry [12].

Grenho (UEMS-EACCME), Juan Palou (ESU/EAU), Julia Rautenstrauch (EULAR) and Robin Stevenson (JECME)

This plenary session, moderated by the representatives from the Biomed Alliance, began with delegates from two European medical societies commenting on forced changes to their normal congress offerings and the resulting implications for the future. The European Alliance of Associations for Rheumatology, (EULAR) reported on their efforts to provide a live event with reduced numbers of physically distanced participants but then being obliged to move to a virtual format. The financial implication of reduced numbers of attendees and reduced revenues for societies was highlighted, although some hope was put forward that smaller live events might strengthen the cohesion of the society. The European Society of Cardiology (ESC) faced similar challenges and opted for a freely available online congress in 2020 that resulted in a threefold increase in registrations over previous congresses. An analysis of the demographics of registrants revealed that the number of female attendees increased dramatically and that much of the increase in registrations came from South American countries. A consensus view from both societies was that hybrid meetings may be the norm for the future to help facilitate networking, seen as a vital component of the traditional congress.

João Grenho, representing the accreditation body of the European Union of Medical Specialists (UEMS-EACCME) described the special accreditation review process for Covid-19 webinars that could allow submission up to one week before the activity. He noted that postponements and programme changes could be catered for and that submission to decision time had been reduced in response to the challenges for educational providers brought on by the pandemic.

Whilst large congresses remain the primary educational offerings of societies, the wide range of their other educational activities was exemplified by Juan Palou, Director of European School of Urology (ESU) which, on behalf of the European Association of Urology (EAU), provides accredited e-courses, surgical education, masterclasses, guidelines, publications, and scientific content from live events to a global audience. His summary of the current situation is encapsulated in Figure 9.

A rather different "devil's advocate" approach was taken by Robin Stevenson Editor-in Chief of JECME who put forward three complaints related to medical societies' educational content and encouraged the societies to consider becoming more involved in workplace-based CME/CPD. He cited the following points:

- societies' content is based on a curricular approach rather than adopting professional gap analysis to elicit deficiency, development, or confidence gaps to initiate planning,
- assessment of outcomes does not seem to drive the design of educational activities in many societies and there is little evidence of the backwards planning model being used,
- an exhortation to societies to submit articles on CME/CPD for publication based on the wealth of research data and experience among their members.

The next set of breakout workshops were as follows.

**3a – The extended event: using technology to reach and engage a diverse audience**Alvaro Margolis (EviMed) and Jann Balmer (University of Virginia)

Alvaro Margolis introduced the workshop from Uruguay by describing the model for the extended


**Figure 9.** A viewpoint from Dr J. Palou [13].

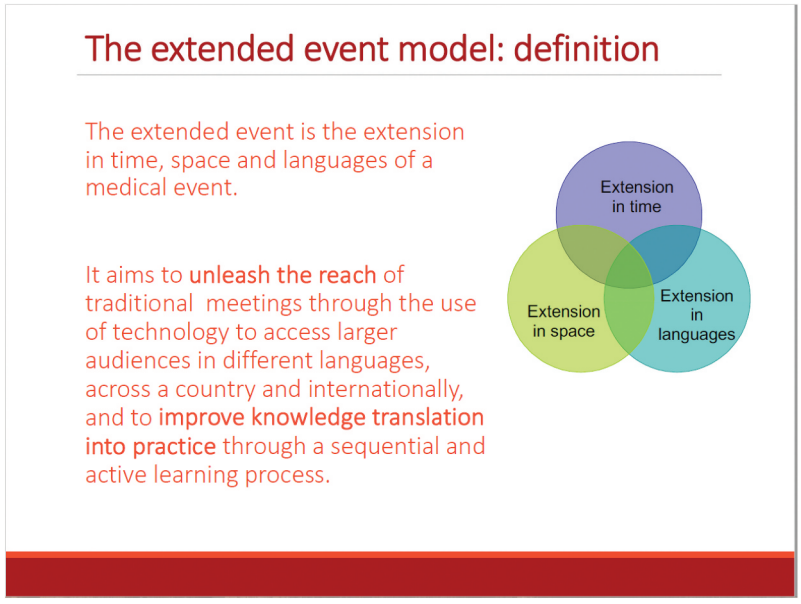


**Figure 10.** Extended learning model [14].

learning activity as shown in Figure 10. This session dovetailed with the preceding plenary by providing an example of a two-month long event based on the model. This event, a congress on peritoneal dialysis, was designed for synchronous and asynchronous interaction with different themes being considered on a weekly basis. Other benefits of this approach are the ability to provide access from around the globe and participation in cohorts based on factors, such as language or geographical location. The combination of synchronous and asynchronous activities allows learners to infuse their participation into their own schedule. Social networking is also a vital component of the model with opportunities for conducting workplace-based projects among cohorts. It was also deemed important to obtain faculty commitment for the duration of their topic to provide an appropriate level of interaction with participants and reinforce the sequential learning. The workshop ended with a short exercise to elicit ideas on how this model could be applied to the forthcoming 14th ECF.

**3b – Patients as teachers and COI as a side effect: How to do it right?**Marcin Rodzinka (Mental Health Europe), Paul Scheffer (FORMINDEP) and Ellie White (Health Action International)

The concept of patient involvement in CME/CPD and concomitant challenges was discussed in relation to the mental health field in Europe. A collaborative approach was proposed and Rodzinka was pleased to note from a poll of participants that, although limited, progress is being made in moving the situation up the "ladder of involvement". Examples were provided of educational activities with measurable outcomes where patients were actively involved in the design and delivery, rather than just being present to tell their story. Scheffer and White commented on the potential for conflicts of interest (COI) in producing educational activities with patient advocacy groups which might receive up to 45% of their funding from pharmaceutical companies. However, it was suggested that current procedures for identification and resolution of COI in accredited CME/CPD could be applied to keep activities with patient involvement transparent and accountable.

**3c – How to provide a truly interprofessional education for clinicians**Sam Kynman and Bart Morlion (European Pain Federation – EFIC)

In an interview scenario, Kynman and Morlion described how the European Pain Federation has attempted to address educational gaps among the diverse range of professions involved in pain management including nurses, psychologists, occupational therapists, social workers, and various medical specialists. The Federation functions on three main pillars of research, advocacy and education and they described challenges encountered in their attempts to introduce interdisciplinary educational sessions into their Pain Schools. Whilst striving to make these educational sessions completely interdisciplinary they have been faced with some resistance from physician groups and healthcare unions not fully understanding the concept of interprofessional continuing education as described by Kathy Chappell later in this report [15]. According to the Federation, pain is a biopsychosocial phenomenon and its management requires input from a variety of professionals and


**Figure 11.** An interprofessional educational approach [16].

a range of treatments. They highlighted a major educational initiative namely the Virtual Pain Education Summit (Figure 11) designed with an educational focus rather than that of a scientific congress to foster more interprofessional education by blending discipline-specific sessions with activities targeted to all members of pain management teams.

## Oral Presentation

Two poster authors made live oral presentations to the forum on Days 2 and 3.

The first of these entitled "***Improving clinical handover for new patient admissions across two surgical wards over the period of 9 months"*** was presented by Heather Davis of William Harvey Hospital in Kent who described attempts to improve protocols for clinical handover of patients from an emergency department to surgical wards. A blend of electronic and paper record-keeping exacerbated the situation where the documentation of patient notes was deemed inadequate. An educational programme based on an audit, reminder notes and posters, was put in place to seek some improvement, which did occur initially but not in the long term. It was concluded that education per se might not be the solution here but there was a need for a culture change involving management and staff to sustain the required outcome. Figure 12 illustrates the poster submitted by Dr Davis and her colleagues.

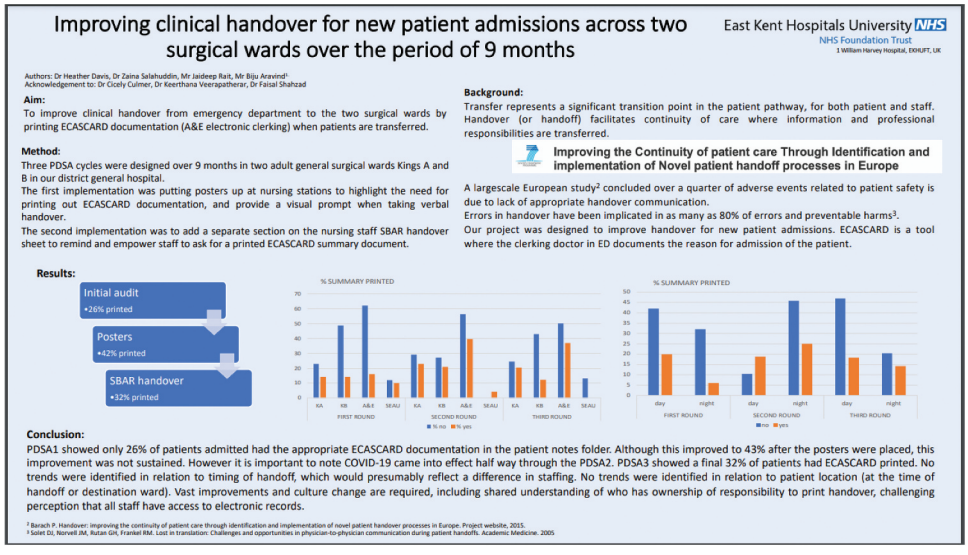


**Figure 12.** Documentation issues in clinical handovers [17].

## Plenary 4: Accreditors

**Standards for substantive equivalency between CPD/CME accreditation systems**Graham McMahon (ACCME), Hilary Hoey (RCPI), Adrian Jennings (RCP), and Reinhard Griebenow (ECSF)

International collaboration among accreditation bodies has grown over recent years leading to formation of the International Academy for CPD Accreditation. The Academy has developed a shared set of standards to provide guidance for the accreditation of global CPD/CME. Graham Mc Mahon of ACCME introduced the workshop by identifying opportunities such as increased attendance and engagement, and challenges such as non-participatory learners related to innovations in educational formats. The standards are being introduced to determine a baseline of substantive equivalency among accrediting bodies. The road ahead is summarised in Figure 13.

Adrian Jennings from the Federation of the Royal Colleges of Physicians of the UK, Hilary Hoey from the Royal College of Physicians of Ireland, and Reinhard Griebenow, representing the European Cardiology Section Foundation, endorsed the adoption of the standards whilst acknowledging the need for balance between local control and international standards. The main benefits from using the shared standards are summarised in Figure 14.

After feedback from participants, two main points emerged – the need for outcomes (patients' and learners') to be a pivotal cog in evolving standards and

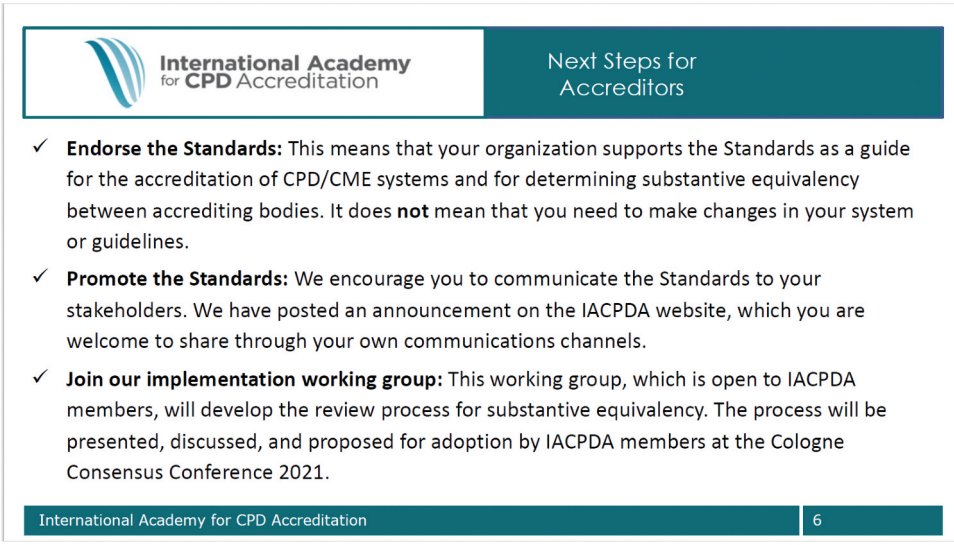


Figure 13. Where next for accreditors? [18].


Figure 14. Potential benefits of shared international standards [18].

a commitment to flexibility and nimbleness in response to innovative educational formats.

Breakout workshops followed the accreditors' plenary session.

**4a – Getting an Activity Accredited in Europe** Mia Neve (Liberum IME), Camilla De Filippi (Siyemi Learning) and Monica Ghidinelli (AO Foundation)

Addressing a gap identified from previous ECF need assessment surveys, representatives of three different European providers described the accreditation landscape in Europe and set out a comprehensive roadmap to help learners negotiate its complexities. The main reason for seeking accreditation now seems to be to obtain a stamp of approval for independence, balance, and transparency rather than seeking credit.

The plethora of accreditation bodies (more than 200) and routes is illustrated in Figure 15.

Various steps were identified in the process of obtaining accreditation and, although the framework for accreditation is fragmented, the presenters were able to summarise the key points applicable across the spectrum of accreditation as shown in Figure 16.

**4b – Process-oriented simulations: A gift to quality and safety**James Ruiter (Salus Global)

This workshop from James Ruiter in Canada focused on the practical application of knowledge in an interprofessional setting based on a process-oriented approach to reveal *work as done* based on the Venn diagram in Figure 17. A Covid-19 simulation case study was provided for discussion among participants

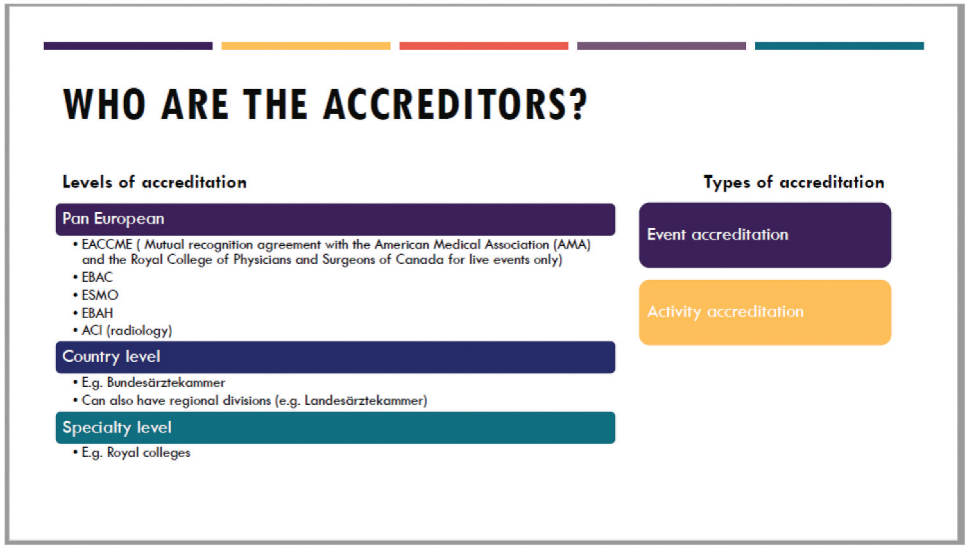


**Figure 15.** The range of accreditors in Europe [19].


**Figure 16.** Key steps in negotiating accreditation in Europe [19].

to demonstrate the process-oriented approach. The outcome sought was the harmonisation of care rather than just having team members "do their own thing". The case study and comprehensive guidelines are available for access at the Forum website https://cmeforum.org/13ECF/

**4c – Adapting to new opportunities in medical education: from f2f to virtual**Diana van Brakel and Margarita Velcheva (Kenes)

This very thorough and interactive workshop looked at challenges and opportunities afforded by enforced changes in moving from a live to a virtual learning environment. The presenters from Kenes Group, based in the Netherlands, described their experiences from having to reformat an educational activity on Alzheimer's and Parkinson's Disease into a virtual meeting at short notice. They shared lessons learned, noting that sound design principles were a major factor in implementing a successful meeting and that many of the challenges to be overcome resided in the now familiar areas of interaction and engagement of attendees. An unforeseen benefit was the ability to more easily capture and repurpose content compared with a live event. An example of successful reformatting of the content is described as *smart education* as shown in Figure 18.

**Day 3** After a review of Session 4 breakout workshops the meeting continued with:

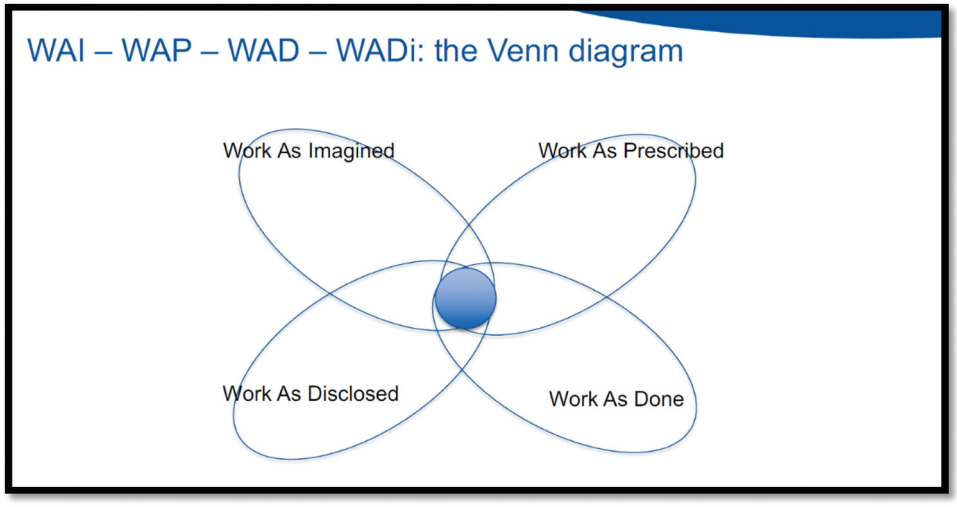


**Figure 17.** Four inter-related "buckets" of human work [20].

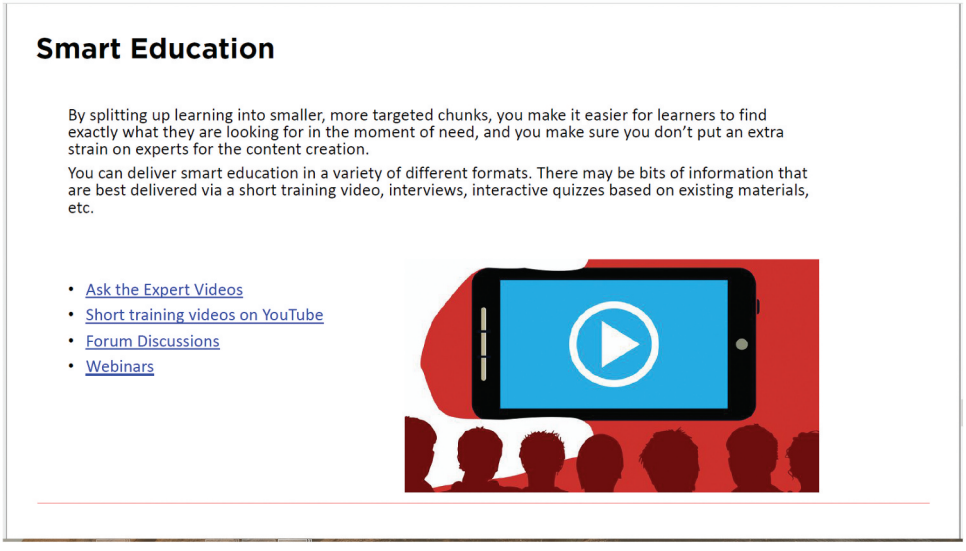


**Figure 18.** Smart education in the virtual setting [21].

## Plenary 5: Providers

**Rapid change and adaptivity: the new essential competencies of CME-CPD providers**Margarita Velcheva (Good CME Practice group), Pamela Funes (Kenes), Thomas Kleinoeder (KWHC), Mia Neve (Liberum IME), Miriam Uhlmann (AO Foundation) and Sophie Wilson (IMP)

Representatives of the Good CME Practice group (gCMEp) of providers considered major challenges and coping mechanisms for educational activities in the era of the pandemic environment from the provider's point of view. Identified challenges Included:

- faculty availability and engagement when they are in the workplace,
- learner engagement,
- the need for nimble responses,
- deficiencies in the digital literacy of faculty,
- duration of meetings

Participants and presenters shared coping mechanisms for dealing with changes and challenges, foremost being the need for adaptability, characterised by the mantra *"be like a palm tree not an oak tree"*.

Technology trends that may transform medical education in the future were also considered, including artificial intelligence, 3-D printing, mixed reality, and extended reality that adds augmented data as illustrated in Figure 19.

The next set of breakout workshops were as follows.

**5a – Developing a pathway for your professional development**Steven Kawczak (Cleveland Clinic) and Chitra Subramanian (AO Foundation; ACEhp)

The current and past presidents of the Alliance for Continuing Education in the Health Professions (ACEhp) conducted a workshop with breakouts to outline a pathway for professional development for CME/CPD professionals. ACEhp has developed a competency-based model that seeks to achieve the following:

- identification of skills needed for excellence in performance,
- categorising the key components of the profession,
- providing a framework for job descriptions, performance expectations and career enhancement,
- supporting a lifelong learning journey.

A broad range of skills and competencies is required in professional teams and ACEhp's list is summarised in Figure 20. In reflection on the workshop, Kawczak pointed out that professional development for CME/CPD educators is a vital foundation for success in helping healthcare professionals provide optimum patient care and he also encouraged the profession to become involved in advocacy to promote the culture of lifelong learning.

**5b – The future is now** Suzanne Murray (AXDEV), Celeste Kolanko (Liberum IME) and Dale Kummerle (GAME)


Figure 19. A technology for the future in medical education? [22].

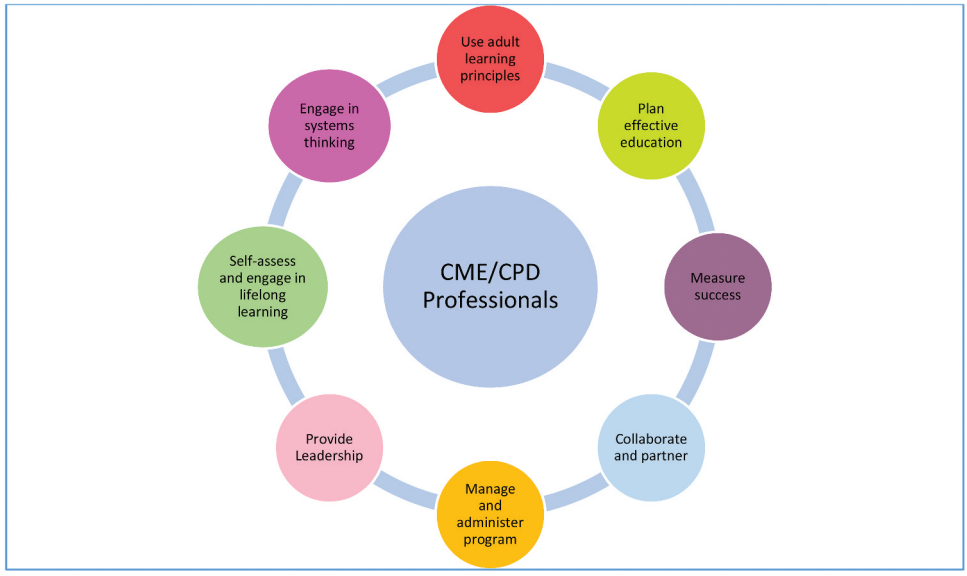


**Figure 20.** Necessary Skills for CME/CPD professionals [2324].

Celeste Kolanko introduced the workshop on behalf of the Global Alliance for Medical Education (GAME) and re-echoed the onset of the current virtual education environment forced by the pandemic, and shared learnings from the Futurist Forum organised by GAME in 2019. The ideas generated at the Futurist Forum were based on the evolution of learning sciences and knowledge translation, the Impact of technology, and the exploration of new collaboration models. These ideas were used as themes to run breakout groups. Feedback from the breakouts once again cited the issues of informal learning, the fact that virtual learning could provide more personalised learning and that the reach of virtual events is potentially much greater. The role of government, particularly in Europe, was considered important in providing strategies for digital and lifelong learning but governmental influence may be limited by an inability to be nimble in response to influences such as the Covid-19 pandemic compared with technology companies working in the educational space.

## Oral presentation

Following the preceding workshops, a second oral presentation from the poster authors entitled ***"Get your evidence first: Informing evidence-based educational interventions with rigorous needs assessments"*** was presented by Olga Salvidio and Sophie Peloquin who summarised the poster shown in Figure 21. They described the mixed methodology study of need assessments used to identify practice gaps that were used in a variety of ways, such as providing background information for a grantor's request for proposals, the design and implementation of activities from both industry and providers, and contributions to the literature of medical education.

## PLENARY 6: Interprofessional Education

**Why do we do what we do?**Lawrence Sherman (AMEE; Meducate Global), Kathy Chappell (ANCC), Trevor Gibbs (AMEE) and Mark Westwood (Barts Health)

This plenary was introduced by Lawrence Sherman as a "passion-based "session and began with Trevor Gibbs, president of the Association for Medical Education in Europe, who focused on the spectrum of medical education from undergraduate through to CME, saying that it was only after medical school that he learned any real medicine. The pandemic has reinforced the fact that we are now a global community where effective education drives efficient and effective healthcare, in a world of change, technology has enhanced learning to a stage of transformative *showing*, rather than just *telling* or *sharing*. Gibbs emphasised the need for common standards to be available for learners and educators; one suggested standard was the principle of learning how to learn and he put forward the notion that medical education has allowed progress to be made as illustrated by Figure 22.

Cardiologist and medical educator Mark Westwood acknowledged that CPD percolates the whole spectrum of medical education and that the impact of Covid-19 has not been entirely positive. As a learner, he was not as enthusiastic as some in embracing the interactions

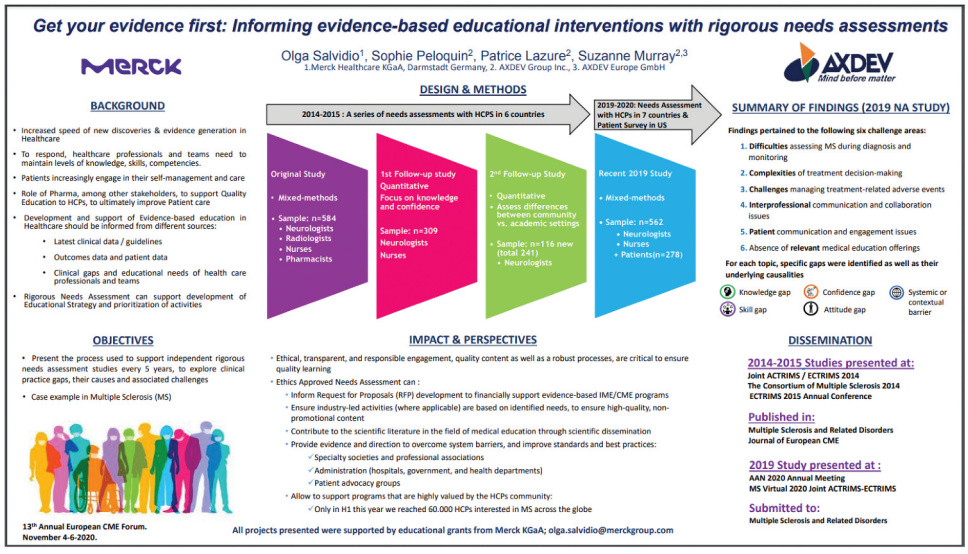


**Figure 21.** Mixed method study of robust needs assessments [24].


**Figure 22.** Progress achieved through medical education [15].

available in the virtual format but predicted a change in CPD from competency to capability, moving from being able to do something to performing the task. He summarised some of the changes that have occurred in the digital world in Figure 23.

Kathy Chappell concentrated on team-based competencies with the theme of collaboration being "by the team for the team". She provided a definition from her organisation as shown in Figure 24.

She emphasised that Interprofessional Continuing Education (IPCE) is not just co-locating learners in the same space but addresses gaps, processes, and outcomes that are relevant to all members of the health care team including the patient and family. She shared some examples to elicit responses to check on whether the situation fitted within the definition above. Her takeaway points were as follows:

- healthcare is provided by teams, not individuals,
- as members of healthcare teams, individuals need to learn from, with and about each other to deliver high-quality, collaborative care.
- patients benefit when members of healthcare teams work well together,
- CE/CPD is a strategic organisational asset to improve interprofessional practice,
- almost all CE/CPD should be considered in terms of team-based learning first!

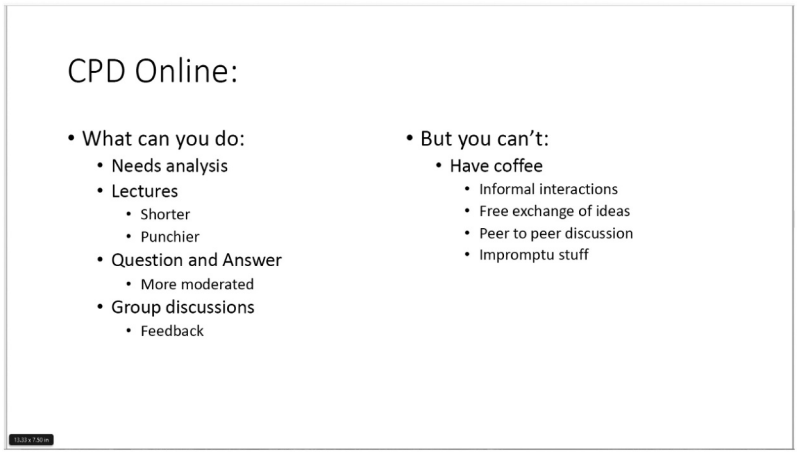


**Figure 23.** Changes associated with virtual educational activities [15].

**Definition of Team-Based Education (or Interprofessional Education)**
*When members from **two or more professions** learn with, from, and about each other to enable **effective collaboration** and **improve health outcomes***
*www.jointaccreditation.org*
*(definition derived from the WHO definition of IPE)*

**Figure 24.** Definition of Interprofessional Education [15].

**Demystifying European & global CME terminology and practices**an open panel discussion and Q&A session, originally promoted for US participants was conducted at the end of Days 1 and 2. The main points that emerged were:

- the possibility of provider (rather than activity) accreditation in Europe,
- infusion of CPD into the workplace in UK and Ireland such as Schwartz Rounds,
- implications of the EU's General Data Protection Regulation (GDPR),
- the role of industry,
- transatlantic opportunities for joint providership.

The main thread that emerged from #13ECF was that the new normal for CME/CPD activities was likely to be a blended mixture of live and virtual activities with micro-learning playing a significant role and innovative methods of providing interaction and networking for attendees being put in place.

European CME Forum has always striven to adapt to the needs of its learners and #13ECF continued to promote the ideals of accessibility and transparency. Sterling efforts were made to provide a worthwhile experience to participants in this virtual version and there was much anticipation for the 14th European CME Forum (#14ECF) due to be held in Barcelona, Catalonia, Spain, 3–5 November 2021 but now being presented in an enhanced virtual format See: https://cmeforum.org/14ECF/

Meeting materials for the 13th European CME Forum presentations are available at the European CME Forum website: www.cmeforum.org and a Twitter stream is accessible at @eCMEf

## Disclosure Statement

No potential conflict of interest was reported by the author(s).

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