

CONFERENCE REPORT

CME/CPD in the Indian Subcontinent: Proceedings from the 1st regional meeting of Global Alliance for Medical Education (GAME) in Mumbai, India

Vaibhav Srivastava¹, Lisa Sullivan² and Shwetal Sanghvi¹

¹Insignia Communications, Mumbai, India

²Global Alliance for Medical Education, USA

Abstract

In today's fast paced environment, continuing medical education (CME) and continuing professional development (CPD) play a pivotal role in enhancement of clinical practice and patient care. Getting updated with the latest trends and practices has gained utmost importance for today's healthcare professional, be he or she a family physician, a specialist or a super specialist. In addition, the increased awareness of different diseases among the masses due to exposure to information from the media and Internet makes it vital for the healthcare provider to be aware of the latest knowledge and trends so that patients may be provided with the highest quality of treatment.

India today boasts of having the largest number of medical schools in the world with an annual student intake of over 50,000 prospective medical professionals. CME in India is at a rudimentary stage in development, but definitely evolving at a rapid pace. Despite the best efforts of the major stakeholders, such as the Medical Council of India (MCI), medical societies, educational institutions and key opinion leaders (KOLs) in the field, the CME scenario in India fails to have a systematic and integrated approach to match international standards. There is a huge need gap because the legislation to make CME mandatory has made little progress. One of the many reasons is that each state in India has its own individual norms, and without a federal system there exists no national guideline for appropriate specialty learning that practising doctors require as part of CPD. There is an unmet need for the provision of the right CME for the right doctor group at the right time to create appropriate learning levels. Therefore CME providers in India need guidance to navigate through rough waters with a multi-modal unbiased approach to bring together the needs of the Indian doctors and the needs of the patient population on a common platform.

This report summarises the presentations and discussions that took place during the first regional meeting of The Global Alliance for Medical Education (GAME) in India on 18 October 2014 in Mumbai. The predominant participants and panel members included representatives from the MCI, medical education institutions, pharmaceutical industries and private sector providers of CME programmes. The conference was organised with the aim of bringing all the major CME stakeholders from India and CME global experts under one roof to discuss the challenges and possible solutions for the expansion of CME/CPD in India.

With this motive as the primary focus of the meeting, eminent speakers and panellists attempted to identify region-specific issues in implementing legal and

Correspondence: Vaibhav Srivastava, Insignia Communication Pvt Ltd, Shreepal Complex, Suren Road, Andheri East Mumbai-400 093, Maharashtra, India. E-mail: vaibhav@insigniacom.com

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regulatory frameworks for CME. The group of experts attempted to identify ways to implement standards of good practice, so that the Indian doctor could match his/her international peers. The role of industry and that of private medical education providers was also discussed at length given their major presence in the country.

Keywords: CME/CPD, India, GAME, revalidation, medical education

Introduction

Vaibhav Srivastava (Programme Director, Director – Insignia Communications, GAME member) presented the welcome address on behalf of Global Alliance for Medical Education (GAME) and the organising team. He began his talk with a brief description of the current continuing medical education (CME)/continuing professional development (CPD) scenario in the Indian sub-continent and the global face of GAME in the field of CME and his privilege to be a part of the organisation.

He emphasised that although the idea of CME has taken root in the country, it continues to face troubled waters in the implementation and integration into the current education system, in order to encourage voluntary participation of the target audience. Lack of a structured and integrated medical education curriculum, non-uniformity in rules for mandatory CME credits, differences in standards of CME accreditation across the states, confusion on the recognition status of online CME and funding policies are some of the hindrances faced in structuring policies and executing CME programmes for the healthcare profession.

He said the purpose of organising this meeting was to bring all the major CME stakeholders in India on to a common platform along with global experts to discuss expansion of CME/CPD. Unlike other countries such as the US and much of Europe, India fails to have a structured methodology for CME programme implementation and recognition in place. In addition to major stakeholders such as the MCI, medical societies, educational institutions and KOLs, he highlighted the pivotal role played by the pharmaceutical industry in helping shape the development of the CME system in India. He said that unlike the rest of the world, the biggest and strongest participation in CME growth and development in India happens to come from the pharmaceutical industry.

He thanked first the key stakeholders for their contribution in organising the event and secondly GAME for having made its maiden journey to the subcontinent. He hoped that this initiative would help to create a cohesive CME environment in India that would improve learning and clinical practice and as a result ensure better patient outcomes.

Greetings from GAME

Maureen Doyle-Scharff (President – GAME)

About GAME

GAME, a non-profit organisation founded in 1995, is dedicated to advancing innovation and collaboration in

CE/CME and CPD throughout the world. Today the organisation boasts of 150 members worldwide. The diversity of the GAME membership comprises academia, health systems, societies, accreditation bodies and industry, thus representing almost all global stakeholders of CE/CME/CPD.

GAME endeavours to encompass CPD, undergraduate and graduate medical education, known collectively as the medical continuum. It is engaged in a continuous pursuit to enable CPD professionals globally to leverage the science of learning and change, as this can help to close the knowledge and practice gaps among healthcare professionals. Creating a network of CPD professionals to collaborate, innovate and elevate the standards of need-based medical education worldwide would ultimately lead to improved patient care and outcomes. GAME is keen and enthusiastic to bring its professional development programme to the country following this first regional meeting in Mumbai, India on October 2014.

CME/CPD in India – vital role of medical schools

Dr. Vedprakash Mishra (Chairman – Academic Council, MCI)

Dr. Mishra emphasised the importance of training the healthcare professional in India especially because of the huge medical fraternity of which the country is proud. He stated that India today can boast of having 404 medical schools, with an annual student intake capacity of over 54000 candidates at the undergraduate level (the highest in the world). This is in addition to around 26000 vacancies that are available on an annual basis at the post-graduate level. India in his opinion occupies a significant place in the global healthcare system.

In his opinion, health today does not remain just a human right. It has been converted to a constitutional right. What matters currently in the world is how this right is extended to the citizens across the globe. One of the significant parameters that will be responsible for the formation of effective global healthcare systems will be the generation of well-trained manpower. The objectives for higher education including medical education ought to be fourfold. It is mandatory that it should incorporate teaching, training, research, and sustainable development for the society. However, it is saddening to see that the current curriculum seems to have lost sight of these significant landmarks.

The main source for the generation of trained health manpower is the medical schools that impart knowledge that is calibrated and updated. Medical education in and around the medical school must lead on to CME that is essential for CPD. There is a need for a competency-based curriculum incorporating distinct domains with a view to strengthening of clinical and problem solving skills. Medical schools could be a complementary mechanism for the purpose of CME-CPD. Further, MCI has directed and is ensuring that medical schools undertake the responsibility for CME as a supplementary mechanism.

He emphasised that it is not enough to produce a classic graduate or an absolutely laudable super specialist. What is needed is the continued lifelong learning of the graduate and not just for the sole purpose of recertification or revalidation. CME is a human exercise in which each one is required to update himself or herself in all possible domains. He told the audience that in 2009, the MCI evolved the concept of a national faculty development programme. This charted the methodology of structured networks for basic medical education technology workshops in the form of recognised medical education centres (regional and nodal).

In India, the number of medical doctors with the Indian medical council has about one million registered practitioners at any time. When we talk of CME for this huge number, we are considering not only delivery of education programmes, but the associated revalidation and recertification for all. The extent of responsibility required is huge, gigantic and unimaginable, as it involves management of medical practitioners from family physicians and surgeons to specialists and super specialists.

There are huge challenges in implementing newer programmes in a country such as India given its great diversity and huge registry. Global guidelines based on accepted principles have to be incorporated in an integrated manner involving the Indian medical associations, regulatory bodies and medical schools.

How these various issues can be transformed into practice depends on the unified participation of the various stakeholders, playing their respective roles to their utmost capacity. The MCI is making an effort to establish standards for CME across the country and will work with all major stakeholders to make this possible.

Medical education – continued learning

Dr. Jitendra Patel (President – Indian Medical Association)

Dr. Patel introduced his talk by stating the well-known doctrine that learning is a continuous process which starts the moment you are born and continues until you die. The young graduate of yesterday stops learning today and becomes uneducated tomorrow. What is considered a gold standard today will become obsolete tomorrow. Given these truths, he asked the audience the very relevant question which provides the answer to the need for CME:

What can be more dynamic than the human body and the science of medicine?

It is thereby imperative that all stakeholders must work towards keeping medical graduates apprised of recent innovations taking place across the globe. But at the same time, we must understand that the *modus operandi* which is executed and operated in the western world cannot easily be implemented in India because of its great diversity. Different modalities of approach are essential, as there is a vast variation ranging from a sector of family physicians to a sector of super specialists in the era of telemedicine. As an example, every time there is an innovation in endoscopic surgery, it is not essential for the family physician to know each and every aspect of this technique or procedure. But at least he/she must be well aware of what is going on in the world, so as to inform his/her patient that these newer avenues are available for consideration. For the super specialists, it is like an ocean where one has to face the tidal waves before they get the very precious pearl at the bottom of the sea. Therefore, the whole concept is different for a super specialist.

Therefore, CME needs to be fragmented in two aspects: it should help the poor family physician cater for the needs of the poorest of the poor in the country and guide the patient to make use of the benefits of affordable, accessible and competent medical services.

In CME, he emphasised that communication is paramount. In the past, doctors were treated as Gods, whereas today a professional approach is expected. Adding to the various challenges is the lack of trust between the patient and the doctor. It is therefore of the highest importance to incorporate into the syllabus the art of communicating with the patient together with understanding all the legal implications because of globalisation.

Before concluding, he expressed his confidence that the galaxy of personalities present at the meeting would arrive at a conclusion on the way to proceed and decide on a road map to achieve the goal of setting up effective CME/CPD protocols for the Indian doctor.

Establishing a good CME ecosystem in India – role of the pharmaceutical industry

Sudarshan Jain (MD, Abbott Healthcare)

Education is the backbone of the healthcare system not only for the doctors, but also for the patients. It helps in improving skills of the healthcare practitioner and also increases awareness among the patients, there by ensuring better dissemination of scientific and medical knowledge. CME is a powerful tool and includes treatment approaches, patient management, new drug delivery, therapy shaping and diagnosis.

This session highlighted the role of the pharmaceutical industry in establishing a good CME ecosystem in the Indian subcontinent. The expansion of Indian companies beyond Indian borders has led to a significant build-up in the accessibility and acceptability of the Indian pharma market which has also resulted in increased awareness of medical education and awareness.

The role of the pharmaceutical industry in this field is a critical one (Table 1).

The European CME environment: integrating an approach

Eugene Pozniak (European CME Forum, UK, GAME Board member)

Pozniak started by looking at the geographical continent of Europe pointing out that the disparity between the numerous countries of the continent is probably more fragmented than the states in India and with smaller populations. He outlined the development of CME in Europe, from its modern origins in 1999, through its development and the recent challenges it now faces. Over the short decade and a half of development, the environment has been evolving, highlighting many lessons along the way, with numerous factors coming into play that effect the way CME is carried out on both national and pan-European levels.

Factors he identified that have recently been introduced and that are shaping CME in Europe include regulatory and legal obligations, such as the anti-bribery legislation calling for transparency of the flow of funding, the European Federation of Pharmaceutical Industries Association (EFPIA) developments regarding “Responsible Transparency” and opening the discussion of approving independently developed education. The European Commission supports a national structure for CME-CPD systems and emphasises the importance of disclosure of financial relationships in order to identify and manage possible conflicts of interest. Europe must also recognise developments in the US such as the Physician Payments Sunshine Act, the Foreign Corrupt Practices Act and the recent announcement that the Accreditation Council for CME (ACCME) is now considering accrediting providers from anywhere in the world. Added to this is the rise in patient and media awareness of CME and ongoing education of healthcare professionals.

With these challenges, Pozniak described how there is an increasing desire for more clarity and direction, especially when it comes to the role of product marketing, industry controlled education and independently developed education. In summary, he hoped that the European experience can provide possible positive lessons for India and that the experience in Europe is only a small piece of a global jigsaw of developments in CME, one where all parties can share experiences and learn from each other.

CME requirements for medical practitioners in the Middle East

Prof. Gita Ashok Raj (Provost. Gulf Medical University, Ajman, UAE)

CME has always been a vital component of the scholarly activities in the Middle East. There is an ever-increasing voluntary participation of private practitioners in these events, wishing to update their professional knowledge and expertise. CME in this region is either fostered by academia, promoted by professional bodies or is imparted as lectures from eminent scholars.

Gulf Cooperation Council (GCC) countries have a great disadvantage of large migrant healthcare workforces of heterogeneous education and practice. Given this diverse group of healthcare workers, these countries face difficult challenges in maintaining the quality of patient safety and healthcare. Although many live and some online local/national/international CME/CPD events accredited by the health regulatory bodies are being organised to overcome this problem, participation of the healthcare worker remains voluntary.

The Health Ministers’ Council for GCC states was established in 1976 for development of health services to achieve the highest possible standards of health for the citizens of the Council members. Their activities include the organisation of conferences, seminars and training courses. While Kuwait offers a voluntary option for CPD participation, the United Arab Emirates (UAE) and Kingdom of Saudi Arabia (KSA) have mandatory CME/CPD activities which are linked to re-registration. This approach has given the latter countries a head start among others in the Middle East in attaining and maintaining high standards of healthcare comparable to the West. In these countries, a range of 10–50 hours of CME/CPD activities must be fulfilled every year not only by the practising physician and surgeon, but also by dentists, pharmacists and other healthcare professionals.

CEPD in Asia and Australia

Lisa Sullivan (President Elect – GAME)

Continuing education and professional development (CEPD) is now mandatory for physicians across all countries except Japan. It is also mandatory for nurses and pharmacists in China, Australia, Indonesia and Korea and is recommended for nurses and pharmacists in Japan. In India, there is no formal rule in place for CEPD for physicians, nurses or pharmacists. A common issue faced by Asia and Australia with CEPD is that formal needs

Table 1. Pharmaceutical industry and CME.

Standard CME	Playing a collaborative role in enabling standard CME	Identifying unmet educational need
High-quality therapy shaping programmes	Spearheading of new quality of medical learning	Local & regional programmes addressing specific need
Living up to the standard of compliance environment-OPPI*, MCI	Collaboration with education providers & institutions to achieve common goals	Using digital platform in bridging the gap
		Global collaboration

*Organisation of Pharmaceutical Producers of India.

Table 2. Current issues with CEPD (Asia & Australia).

Bad news					
Formal needs assessments rarely done within country, e.g. decisions based on expertise of the societies/states (Asia)	Predominantly based on skills & knowledge only, e.g. little QI or PI (Asia)	CME terminology rather than CPD still the key concept (Asia)	Vast differences in delivery across countries (face-to-face vs. online & blended (Asia much less online than Australia))	Focus on QI rather than PI (Australia)	Too much editorial control from Pharma (Regionally)
Major discrepancies between urban and rural education/availability (common issue).					

assessments are rarely done. Also, there exist major discrepancies between urban and rural education and availability (Table 2).

The WHO has documented that the major challenge faced with implementation of CEPD in these regions is the lack of motivation, absence of need-based accredited programmes, incentives and legal bindings. There is a need to design high-quality tailored courses to meet specific needs.

Where is the field going in Asia?

There is a greater move towards mandatory CEPD for all healthcare professionals with the increased international interest in Asia bringing forth skills, funding and teaching (Figure 1).

An ideal scenario for CEPD development in Asia would be the establishment of a truly regional think tank to share resources, develop cross border accreditation, improve teaching, use a common language (preferably English), create better equality among the healthcare professionals and finally to increase the funding.

Doctor revalidation in UK

OnMedica Aimee Brinzer (MD, Wilmington Healthcare)

Revalidation in the UK has been established since December 2012 for doctors in all sectors with an aim to increase quality in healthcare and provide reassurance for patients and employers. The process involves review of the annual appraisal of doctors by a responsible officer before recommendation to the General Medical Council (GMC)

for revalidation. Revalidation is required every 5 years. This system is under the control of the GMC and the 20 or so Royal Colleges and Faculties of the individual specialties. With a growing trend towards making CME compulsory, the doctors are in need of easy tools to track their CME and reflection. Companies such as OnMedica PDF tracker meet the need of integrating these tools into CME platforms.

CME environment in India – a snapshot

Dr. Rajesh Upadhyay – President Elect – Association of Physicians of India (API)

In the existing CME/CPD global ecosystem, CME is compulsory in North America, Europe and Australasia. There are more than 800,000 qualified doctors in India. More than 70% are private practitioners and see patients at the primary care level. However, fewer than 30% are part of various professional associations engaged in CME for practice enhancement. Practice enhancement among Indian doctors occurs mostly through experience, practice, international publications or conferences, knowledge update information provided by medical sales representatives and CME programmes that may or may not be biased. The Indian CME ecosystem is depicted in Table 3.

CME regulators in India

MCI is a statutory body with the responsibility of establishing and maintaining a high standard of medical education

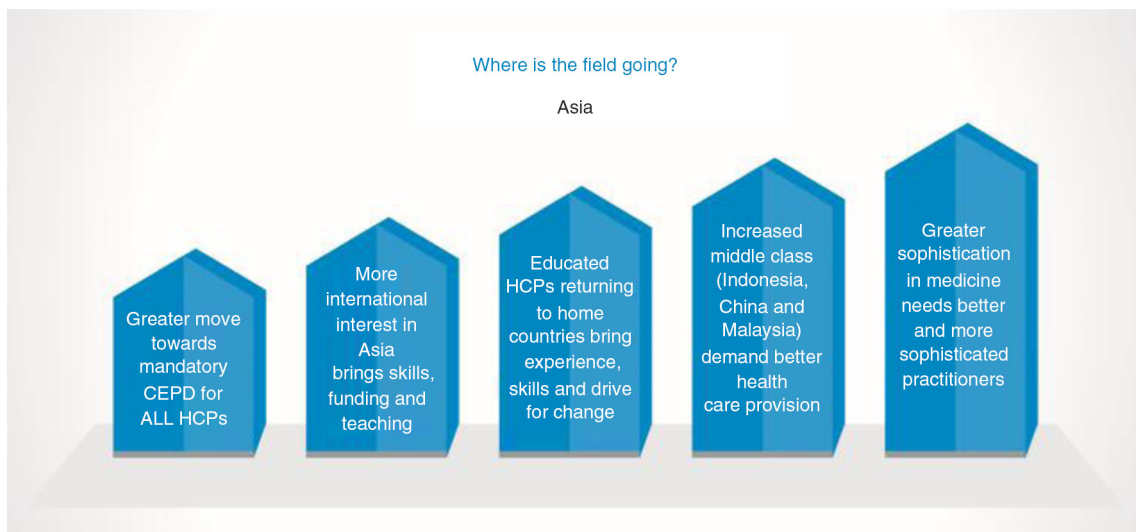


Figure 1. CEPD trend in Asia.

and recognition of medical qualifications in India. In April 2011, MCI passed a resolution on CME as –

“Mandatory for all doctors to attend 30 hrs of CME in every 5 yrs. If they fail to attend, their registration to practice would be suspended”

CME Credit points can be gained by-

- As a co-author / author in indexed national/International medical journal
- Dr. pursuing PG course –like Diploma, MD, MS, DNB & DM (4 points/year)
- Dept. & Institutional activities like journal club meeting, mortality conference etc.

.....ONLY 20% Drs falls under MCI regulations

Other CME regulators are shown in Table 4.

Challenges faced in implementing CME/CPD in India

- Needs to be made mandatory nationally
- Programmes to have a wider reach in rural and semi-urban areas
- Need-based CME defined by professional bodies
- Unbiased industry involvement expected
- Expectation of MCI to have a bigger role in funding rural CME
- Need to increase e-learning and webcasts
- Review on the credibility of independent CME providers

Public private partnership (PPP) in health education

Dr. Narendra Saini (General Secretary – IMA)

Public-private partnership in health care mainly focuses on people and the important parameter of patient satisfaction (Figure 2).

The main objectives of PPP include improving access and quality of essential services, exchange of expertise, improving efficiency and increasing scope and scale of services. Potential benefits of PPP include cost-effectiveness, higher productivity, accelerated delivery, shift in focus from service inputs to outputs and enhanced social service.

Challenges faced in PPP in healthcare include:

- Cost containment
- Effective use of private resources
- Logical diversion of public resources
- Synergy to reduce duplication
- Resource mobilisation

Role of medical education companies in India

Dr. Saurabh Jain (Vice President – Multi-Channel Marketing, Patient Enablement Service and China Business Unit; Indegene Lifesystems)

This session highlighted the role of medical education companies in promoting and developing CME in India.

Globally, it has been seen that medical education companies have maximum reach and high acceptance. Medical education companies make the investments required to develop multiple platforms of delivery while also employing dedicated skilled resources to enable the development of interactive and interesting CME programmes. They are best positioned to develop programmes, which amalgamate related expertise from different sources – faculty from different institutions, presentations of doctors of different specialties and from different conferences to create more comprehensive CME programmes. They are best equipped to arrange the commercial support required to develop and administer CME programmes. Unlike hospitals and medical associations, CME is the core activity of third party CME providers – the only one that pays the bills.

However, parallel to these advantages, it is also of vital importance to ensure that CME developed by medical education providers is not influenced by sponsors' commercial interest. Additionally, the CME developed can fill the knowledge gaps in the target audience with allocation of credit points to the right healthcare professional with right measurements.

CME ecosystem in India – What is needed? (Table 5).

Table 3. Indian CME ecosystem.

CME regulators	CME facilitators	CME seekers	CME providers
<ul style="list-style-type: none"> • MCI is the national governing body • Supported by 26 State Medical councils • Made CME acceptable in India before it becomes mandatory 	<ul style="list-style-type: none"> • IMA (Indian Medical Association) is the largest voluntary organisation in India helping doctors to meet MCI CME criteria • Indian doctors organisations (including API) – responsible for research, knowledge update, publications, organising conference, etc. 	<ul style="list-style-type: none"> • Doctors and nurses • Most of whom are not motivated for CME • No seriousness in CME, as not mandatory 	<ul style="list-style-type: none"> • No such recognition as CME Providers in India • Most of the Medical Education companies deliver CME programmes in India • Major focus is on brand promotion rather than independent unbiased education

Table 4. CME regulators.

State Medical Council	All state councils follow MCI CME standards but only four of them have made it compulsory. Only live CME is recognised.
Indian Medical Association	More than 1700 branches Organises monthly live class room CME with local speakers sponsored by Pharma companies CME credits awarded by state council but unstructured & unorganised
Association of Physicians of India & Individual Certification Programs	APICON – Research, latest in therapy/technology, update, controversies, debates, post-graduate CME, workshops Medicine Update Book every year distributed free to all members

APICON: Annual Conference of the Association of Physicians of India.

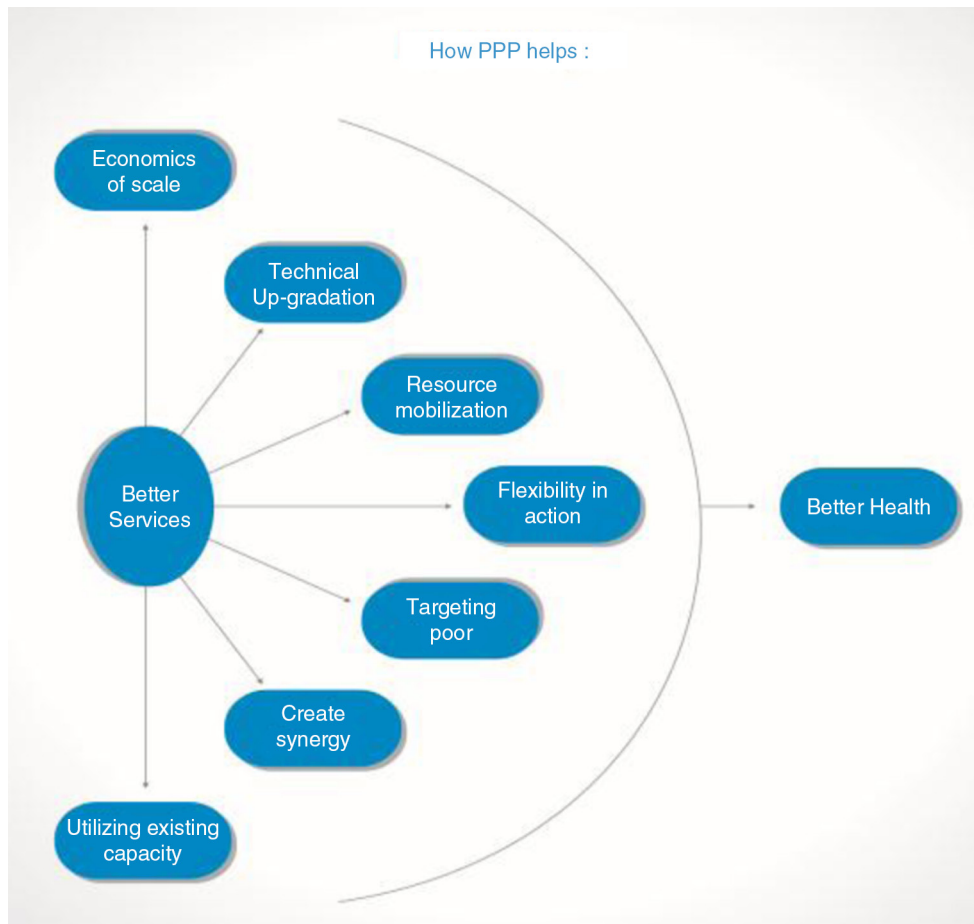


Figure 2. PPP in healthcare.

CME as a bridge to quality

Alok Khettry (Sr. Director – Sanofi)

The pharmaceutical industry is proud to play a leading role in sponsoring medical education for physicians. This is a collaborative effort that serves the mutual interest wherein the physician is informed of the latest medical development and the patient benefits by receiving the most up-to-date and appropriate care. Industry support for CME is crucial in the light of uncertainty in funding of the programmes from other private and government sources.

However, doubts are raised on the credibility of industry-sponsored CME with respect to quality of content and biased emphasis on brands or products rather than targeting unmet needs in disease management. There is also no

clarity on the recognition of this CME for the award of credits.

As the old adage goes, “Transparency is the key to success,” and so industry-sponsored CME must be free from commercial bias, and use generic names whenever possible. The therapeutic options discussed in an activity should be objective and balanced. Industry should make voluntary disclosures about educational grants and honoraria.

The way forward

The session concluded with some introspection around endeavours to ensure CME is successful at the present time while developing further programmes with a more global application in the future. Emphasis was laid on the need to form robust, commercially productive partnerships with

Table 5. CME ecosystem: needs in India.

Regulatory bodies	CME provider	Commercial sponsors
Medical Council of India	<ol style="list-style-type: none"> 1. Medical schools 2. Teaching hospitals 3. Medical associations 4. Medical education companies 	<ol style="list-style-type: none"> 1. Pharmaceutical companies 2. Diagnostics companies 3. Medical equipment companies
<ul style="list-style-type: none"> • Needs comprehensive framework of need assessment, development, accreditation and credit point allocation • Guidelines for CME providers and commercial sponsorship 	Strictly follow framework of regulatory body	Identify mechanism to ensure funding that is not influencing CME content

more associations, societies and other organisations. The ultimate goal should be to deliver content in the ways that the consumer wants, so as to lead to better healthcare outcomes.

Summary

The first regional meeting of GAME in Mumbai involved sessions and lively debate among the committee members of GAME, Indian doctors, pharma representatives and

experts from medical education companies. The participants from India and over the globe highlighted issues pertaining to the current scenario of CME in the Indian subcontinent. They discussed methods and approaches to overcome these challenges and how to ensure best practice and improve the quality of CME programmes. The role of the various stakeholders in CME for India, such as medical societies and industry was a key point of discussion during the meeting, with some clear directions emerging for future dialogue and discussion.