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## Roundtable Discussion

# Should We Eliminate Pharmaceutical Funding of CME?

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Medscape Internal Medicine. 2009; ©2009 Medscape

Posted 01/13/2009

## Robert W. Donnell, MD



One of my great teachers advised his departing medical students: *Lifelong learning is your responsibility. No one is better suited than you to determine your own educational needs.* That advice, with the help of readily available self-assessment tools, has served me well throughout my career. The opportunities for continued learning are now better than ever due to the development of the Internet. Unfortunately, there is a movement afoot to limit those options. A growing McCarthyesque purge seeks to restrict our educational choices by banning industry support of continuing medical education (CME).

## Background

With the proliferation of new drugs in the 1950s and 1960s, organized medicine became increasingly concerned about the educational needs of practicing physicians. At the same time, the pharmaceutical industry realized a substantial commercial interest in marketing its products to physicians.<sup>[1]</sup> A partnership between the profession and industry in the continuing education of doctors was a natural outgrowth. By 1975, the cost of CME was a growing concern, and it was recognized that outside sources of funding were needed to help defray this cost.<sup>[2]</sup> In the ensuing years, CME became increasingly formalized and tied to licensing and credentialing.<sup>[1]</sup> However, as industry support for CME grew, so did concerns about bias and commercial influence. Regulatory safeguards and firewalls were gradually built. Today's CME is highly regulated to ensure transparency and compartmentalization between marketing and educational content development. These safeguards, however, are not enough for those who want a complete ban on industry support for accredited CME.

## The Unintended Consequences

Whether a patient privacy law or a clinical performance measure is being proposed, there are always unintended consequences to consider. Given that CME receives more than half of its support from industry,<sup>[3]</sup> it's easy to anticipate the effect of a ban on doctors' educational choices. Extensive experience as both a planner and a participant of CME activities has taught me that our options for continuing education would be severely limited without some degree of industry support. Nearly all high-quality educational conventions sponsored by professional societies would cease to exist. Many accredited, cost-free Internet offerings would be a thing of the past. If pharmaceutical companies were banned from spending money on accredited CME, those funds would, in all likelihood, be spent on marketing. Physicians would be bombarded by even more information from industry, but in the absence of the safeguards and quality standards of accredited CME.

## The Evidence

The inevitability of unintended consequences places a burden of proof on the proponents of a ban. Is there evidence to

sustain that burden of proof? No. Although the published literature is filled with opinion pieces speaking against industry support,<sup>[3,4]</sup> no evidence exists that such support degrades educational content or has an adverse effect on patient outcomes. According to survey data, an overwhelming number of CME participants found commercially supported offerings to be unbiased and of comparable quality to nonsupported offerings.<sup>[5]</sup> Furthermore, a recently published literature review showed that the Accreditation Council on Continuing Medical Education (ACCME) found no evidence that commercial support for CME results in bias or adverse effects on patient care.<sup>[6]</sup>

## The Belief System

Unable to marshal evidence to support their proposal, the proponents of the ban have appealed to a set of beliefs. One such belief is based on the caricature of a credulous physician incapable of critical appraisal of educational content. Anthony DeMaria, MD, Editor of the *Journal of the American College of Cardiology*, disputed this popular distortion in a recent editorial:<sup>[7]</sup>

I have a further, even more basic, reservation about the proposal to end commercial support for CME. Inherent in such an action is the idea that physicians are like sheep: easily led and without the ability to recognize biased or slanted information. I find this demeaning to the profession. In my experience, physicians are more skeptical than naïve; by nature they are not anxious to accept, but rather are waiting to be convinced. Given the competitive demands entailed in becoming a physician, we are likely intelligent enough to recognize bias when it is present.

Even worse is what follows from this faulty premise: Mind-numbed doctors need an intellectually lazy solution for the appraisal of educational content -- a litmus test. If it's accredited and not industry-supported, it must be trustworthy. Doctors deserve reliable CME offerings, but no litmus test is a substitute for the critical appraisal and review of primary sources.

## Conclusion

It would be a mistake to end industry support of accredited CME. A ban would restrict doctors' choices. Pharmaceutical companies would divert CME funds to purely promotional materials, diminishing the overall quality of information to which doctors are exposed. Proponents of a ban have failed to sustain the burden of proof that benefits would outweigh the unintended consequences.

## Pennie Marchetti, MD



After decades of dealing with third-party payers, there's one cliché that we physicians should know to be true: "He who pays the piper calls the tune." However, when asked whether the pharmaceutical industry should continue funding our CME instead of ourselves, we answer with a resounding "Yes!" Seven years ago, 73% of Medscape readers saw nothing wrong with pharmaceutical industry sponsorship of medical education. More recently, 66% said that they oppose a ban on pharmaceutical industry sponsorship. Although Internet surveys tend to be less reliable than conventional polling, most published studies show similar attitudes.<sup>[8-10]</sup>

The pharmaceutical industry and the medical profession have long been intertwined. However, times have changed, and it's time to reconsider the relationship. Today's pharmacopoeia is bulging with drugs that vie with one another for market share. Where we once had 2 or 3 drugs to treat 1 illness, each with a different mode of action, we now have 5 or 6 drugs with the same pharmacology. Which angiotensin-converting enzyme inhibitor is best? What form of insulin? Which beta-blocker? We all have our opinions, and chances are they were shaped not only from our experiences, but also from what was learned at a conference or lecture. We would like to think otherwise. The common refrain is that doctors are too smart, too sophisticated, too educated, and too professional to be influenced by drug company propaganda. We can spot the bias and sort through the information. If this is true, why do so many of us also believe that our colleagues are unduly influenced by drug company propaganda? Clearly, at some level, the majority of us understand that the pharmaceutical companies are buying influence with their sponsorship; we're just loathe to see ourselves as part of the problem.

Finally, who wants to give up the perks of drug company sponsorship? Without their generous donations (over a billion dollars/year since 2004),<sup>[11]</sup> we would have to foot the bill ourselves. That would mean higher professional society fees and higher attendance fees. We would also have to settle for less luxurious settings and say good-bye to our cheap,

tax-free vacations. As a physician in a private solo practice, I understand the sting of forgoing these perks, but we're already paying a heavy price for our alliance with the drug companies: our integrity and our patients' best interests. The following excerpt comes from a drug industry insider's online blog on the future of online CME and the return on investment compared with traditional conferences:

As far as pharmaceutical marketers are concerned, the more physicians that get CME credits online, the less likely they are to attend live events where collateral marketing can easily occur... The bad news -- for pharma marketers -- is that pharma's return on online CME investment may be much less than for live events such as symposia at medical conferences. The good news is that it costs much less to deliver online CME than live CME. It could cost so little that physicians may actually be enticed to pay for it themselves rather than accept pharma's charity and possible influence over the content! Ha ha ha ha ha ha ha ha ha ha! If you think that will happen, please see [www.brooklynbridgeforsale-cheap.com](http://www.brooklynbridgeforsale-cheap.com).<sup>[12]</sup>

That guy's got our number, and so does everyone else in his business. It's time for us to acknowledge our susceptibility to industry influence. We may see ourselves as wise sophisticates who are too clever to be tricked by marketing ploys, but everyone else sees us as cheap fools.

### Bradley P. Fox, MD



Should pharmaceutical money be accepted to support CME? I say wholeheartedly, "yes." All CME costs money to produce, no matter the method -- grand rounds; large group lectures; enduring materials through journals, podcasts, Webcasts, or point-of-service learning; small group learning; or any of the multitude of opportunities. It is also costly to score, accredit, and record. This money has to come from somewhere, and I say that it should come from anywhere and anyone able to provide it.

The question of funding is easy to address. The problem arises when some equate the funding of CME with the production of CME -- 2 entirely different entities. Certainly, for-profit organizations exist that provide CME activities that are funded by industry and are nothing but thinly veiled commercials for the supporters' products. I agree that this is wrong. However, it is not the funding that makes it wrong, but the CME content itself. As I type this commentary, I am returning from a 3-day meeting with a group of talented, intelligent physicians and skillful staff, where we planned a large CME conference expected to serve over 5000 physicians. As we assessed the proposals for CME sessions, the topics, speakers, learning needs, and methods of teaching were all evaluated. We have strict rules to keep all bias out of the presentations, including requiring up-front disclosures of conflicts of interest, not allowing the use of proprietary names during presentations, and having monitors for all of the underwritten sessions to ensure that there is no inherent or implied bias. The integrity of our CME is taken very seriously. Whether a topic had pharmaceutical funding was not taken into account. Much CME is funded by pharmaceutical money. The key is to keep those who are paying for the CME out of the production process.

Many members of medical societies believe that pharmaceutical money should not be allowed because physicians will be unduly brainwashed. I have a real problem with this as well. The lanyard that holds the CME participant's name tag may be branded with a drug name. The pen that the physician writes with may have a drug name on it. The notepad on which the physician takes notes may be emblazoned with a drug name as well. Someone in marketing must have shown that this can cause a physician's prescribing pattern to change. I say shame on any physician who changes his prescribing behavior because the bus that he rides to the convention center carries the logo of a branded drug. Shame on the physician who changes her prescribing because the pen she writes with has a branded drug name on it, and shame on the physicians who change their prescribing because a drug company underwrites the CME that they obtain. We need to do a better job of training our physicians to understand what evidence-based medicine is. We need to train our physicians to recognize biased presentations and how to resist the direct-to-consumer (read direct-to-physician) marketing done in some of those thinly veiled commercials masquerading as CME. We need to train our physicians to weed out the less-than-quality from the quality, and to go to a CME event, not because it is convenient and free, but because it is evidence-based and of quality.

Pharmaceutical Research and Manufacturers of America (PhRMA) recognizes that physicians are changing their views on this topic. In January 2009, self-imposed PhRMA rules will change the world as we know it. The representatives who come to our offices will no longer be bringing the pens and pads, coffee mugs, and other items that we have come to expect and use. Why? Is it really because they are being proactive, responding to patients' worries that the cost of medicine is too high because physicians are prescribing the newest, most expensive products after receiving pens and notepads? Of course not. The reason behind PhRMA's change in policy is the finding that physicians are not as influenced by gifts as they were in the past. The marketing money can be spent in ways better than buying pens and

pads. The outward message is that "the public has spoken," but the true message goes much farther. Physicians are much more likely to use generics now. We are much more likely to seek the most cost-effective options for our patients. Physician and other healthcare provider thinking has evolved over the past several years. We have been forced by the economy and reality to look for the best evidence-based medicine, and our CME has moved to the best, most cost-effective, evidence-based medicine as well. The time when a labeled pen or a sponsored talk could change the practice of medicine is very close to being over.

My hope is that we continue to push ourselves to practice the most cost-effective, evidence-based medicine and that we strive to make our continuing professional development just that -- professional development, not just medical education. Let everyone and anyone pay for it, but be certain to separate those who produce it from those who support it in order to keep the product clean and free of bias.

## Robert M. Centor, MD



Physicians need CME. Medical practice changes as we learn more about disease, diagnosis, and treatment. Those who graduated from medical school more than 10 years ago can identify major changes since graduation. As a physician who graduated more than 25 years ago, I will give a few major examples. We have new infectious diseases, eg, HIV, methicillin-resistant *Staphylococcus aureus* (MRSA), and Lyme disease. Hypertension is treated predominantly with drugs that were not available in the 1970s. In those days, we could not reduce mortality in heart failure; ulcer disease was treated with surgery; and patients required 6-8 weeks to recover from gallbladder surgery.

We have seen, and will continue to see, dramatic advances in medicine. CME offers us the opportunity to build on our knowledge and improve as physicians. Physicians also benefit from CME activities that reinforce and refresh existing knowledge.

I would hope that CME activities are designed through the use of needs assessments. We should have assessment processes that identify those areas with a need for new knowledge, as well as a sufficient number of patients, to make knowledge dissemination worthwhile. We should have unbiased experts specify the curriculum for CME.

Externally supported CME tends to focus on diseases for which the supporting company has a financial interest. If a company produces a drug used to treat chronic kidney disease, it will happily fund chronic kidney disease talks. If a company sells radiofrequency ablation catheters, it will fund talks on arrhythmias.

I think the problem quickly becomes obvious. By allowing external support of CME, we get CME activities targeting diseases that require expensive treatments. Even if the lecture does not specifically refer to a product, the funders understand that focusing on that condition will increase awareness and indirectly increase the use of their drug or device.

External funding thus directs our focus. I would rather see CME activities that focus on issues with a need for physician education.

Externally funded CME can provide education, but I submit that by its nature, the topics are biased. I hope for unbiased subject selection. Therefore, I would like to ban external funding for CME.

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Disclosure: Robert W. Donnell, MD, has disclosed no relevant financial relationships.

Disclosure: Pennie Marchetti, MD, has disclosed no relevant financial relationships.

Disclosure: Bradley P. Fox, MD, has disclosed that he has served as a speaker for Eli Lilly.

Disclosure: Robert M. Centor, MD, has disclosed no relevant financial relationships.

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