Let Science Prevail: Embracing the Ultimate CME Strategy

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INTRODUCTION

Practical strategies are needed for the survival of CME in the current environment in which pharmaceutical companies and CME providers must interact. Specific issues that are essential to the development of these strategies include CME collaboration, speakers’ bureaus, outcomes measurement, letters of agreement, and content development. It is also important, however, to address this theme from a broader perspective, that of collaboration, partnership, and just plain working together in an environment plagued by presumption of nefarious intent, conflict of interest, and a whole new form of profiling. This review addresses how we have gotten to where we are today and where we are going regarding CME, focusing in particular on the most contentious element of CME today. That element is funding, specifically the pharmaceutical industry funding of CME, one of the main reasons for discussing practical strategies for survival in the first place. Survival is not too strong a word, because the very guidelines designed to protect the independence of CME threaten the very future of CME. More specifically, we must focus on the thinking that has brought us to this point, how this thinking threatens not only CME as we know it but also our ability as a nation to cure our chronically ill healthcare system, and finally, our opportunity and obligation to correct this thinking.

We do have an opportunity to straighten out this thinking to ensure that science, with its power to inform better patient care, prevails over bias against the pharmaceutical industry, against the industry’s involvement in CME, and against the industry’s role in improving the broader healthcare enterprise in the United States.

Ensuring that science prevails is the ultimate strategy for survival in both the CME environment and the healthcare environment as a whole. This strategy is the foundation on which all others must be built. Just as the success of CME depends on the free movement of the best information available, so too does our ability to shape a healthier US healthcare system.

WHERE IS CME GOING?

CME, which has been an effective means for providing physicians with the latest scientific and medical information to help them serve patients better, has turned into yet another referendum on the pharmaceutical industry. Actually, referendum is too generous a description of this process, because the debate over the involvement of the pharmaceutical industry in CME—that is, involvement of companies regulated by the US Food and Drug Administration (FDA)—has been decidedly one-sided. The thinking behind the debate is pointedly ironic and cynical, and the results are sometimes bizarre. The late Dr. Shickman, who was a leader in demonstrating the value of CME in the quality of patient care and for whom the Shickman Lecture is named, would probably support the goal of achieving a more balanced discussion in the interest of patient care, a goal we can work to attain.

HISTORY AND DEFINITION OF CME

The earliest days of CME can be traced to 14th-century Venice. There, from 1300 to 1801, a form of specialty certification for medical practice was available for all licensed practitioners and required yearly attendance at refresher courses in anatomy, a requirement that “provoked ingenious evasions, which the Venetian government continually tried to overcome” [1]. Continuing medical education came

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into being in the United States in the late 1920s, when the limitations of the initial medical training of physicians were recognized. Medical schools created a classical system of continuing education. The first mandatory program was initiated in urology in 1934.

Today, with medical school training greatly advanced, the primary role of CME is defined by the Accreditation Council for Continuing Medical Education (ACME) as follows: “Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession” [2]. This definition is similar to the one used to describe CME at Pfizer and throughout the research-based pharmaceutical industry. Pfizer’s guidelines state that CME grants “must serve a clearly defined, legitimate research, health, education, or scientific purpose,” and that they “must result in educational output and/or directly benefit patient care” [3].

PERCEPTION OF THE PHARMACEUTICAL INDUSTRY’S ROLE IN CME

Despite the view of the purpose of CME that is shared by the ACCME and the research-based pharmaceutical industry, the medicopolitical complex has shaped a perception of industry’s role that is summed up in these words, published in the New England Journal of Medicine in 2005:

Although there are no overall data on the frequency of commercial bias in CME, some of the physicians who are invited to speak at CME events or to organize them have extensive financial relationships with industry and have been paid to give other talks as part of the speakers’ bureaus of drug companies [4].

Marcia Angell, a New England Journal of Medicine editor, put it more bluntly in her book: “The adage is right,” she wrote. “He who pays the piper usually does call the tune, regardless of efforts to make it appear otherwise” [5].

From this perspective, one point that seems clear is that any relationship with a drug company is negatively perceived. The intentions of drug companies are not to be trusted, and policies originating with the pharmaceutical industry must be wrong. Conflict of interest is inherent and must be managed, if not eliminated. The same negative perception seems to apply to anyone with an association with the industry. This presumption of conflict exists despite the fact that the pharmaceutical industry invests more in biomedical research, physician education, and health literacy and does more to help improve human health than any other industry.

Where this negative perception and its consequences will end is not clear. But the continued tarring of the industry—whether by peer review, disclosure, or other means—will result in educational output and/or directly benefit patient care. It would be only natural if some in the industry, tired of having so much rhetorical sand kicked in their faces, decided to vacate the CME space altogether.

Critics of the pharmaceutical industry would no doubt delight in its abandonment of support for CME. But it is hard to see how such action would actually benefit CME or improve health outcomes. In addition to providing the bulk of CME funding, pharmaceutical companies generate much of the world’s most advanced biomedical research. Pfizer alone accounts for 15% of all such research conducted worldwide, making this company the single largest private biomedical research organization in the world. Without Pfizer’s support of CME, how would all of the information and all of the data contained therein find their way into medical and clinical discourse and from there lead to benefit for patients?

THE PHARMACEUTICAL INDUSTRY AND CONFLICT OF INTEREST

The facts regarding the positive impact of the pharmaceutical industry on healthcare seem to do little to ameliorate the negative perception of the industry, a viewpoint that has been codified in the guidelines-rich environment that we are discussing. Consider, for example, the rules regarding financial relationships with so-called “commercial interests,” relationships that qualify as conflicts of interest. Rather than asking ourselves why pharmaceutical companies are included among commercial interests in the context of CME conflict-of-interest rules, we might ask why health insurers, group medical practices, for-profit hospitals, and others are not considered commercial interests in this context.

This question is not meant to suggest that organizations that provide commercial services to patients should not sponsor or participate in CME, as they clearly should, but instead suggests that the CME community should manage all financial conflicts of interest in the same way—whether by peer review, disclosure, or other means—with one standard that applies to everyone.

Because conflicts of interest are not unique to FDA-regulated industries, the existence of rules that apply only to these industries is confusing. Certainly, in our commercial healthcare system, health insurers, group medical practices, and for-profit hospitals are very much commercial interests themselves. And just as certainly, if self-serving intent is presumed to be behind any commercial interest, then, based on the economics of our system, each entity has an incentive to influence medical practice in places of greatest self benefit. For example, a health insurer might want to promote the use of generic drugs over brand-name prescription medicines, not because this practice leads to better medicine or produces better outcomes, but because it is cheaper for the insurers and they might make more per-unit profit.
Clearly, any search for conflicting interests in CME will reveal them, in association with pharmaceutical companies, insurers, hospitals, and others. Economics and commerce, which are inextricable parts of all elements of our healthcare system, ensure this. Some believe, however, that bias in CME is not necessarily a function of finances, but rather is the result of unwillingness to consider ideas that are different from one's own. Consider the peer-review system of the National Institutes of Health, and whether truly novel ideas—ideas that challenge the status quo—are likely to make it to the funding stage. Experts always possess some form of bias as a natural byproduct of their experience.

Hypothetically, if all professional bias were eliminated—a situation that could not occur in reality—CME would cease to exist, because bias and conflicts of interest are ubiquitous. And if we could eliminate bias and apply conflict-of-interest standards consistently, we would almost certainly exclude all of the top experts in a given field.

Methods other than disqualifying experts can be used to manage conflicts of interest. These include peer-review and reference to the best available evidence. But these processes should be applied to all, regardless of whether financial ties exist with FDA-regulated industry, because universal application is the only policy that is fair and consistent with the recognition that all parts of the US healthcare system are industries in their own ways, with each engaged in business, commerce, production, and trade of something.

The focus of special conflict rules only on those entities with ties to FDA-regulated industry encourages the exclusion from CME of those who, based on breadth and depth of experience, may be the best experts in science and medicine. Thus this policy can serve only to restrict the free trade, or flow, of scientific and clinical information. Unfortunately, the ultimate losers in this scenario are the patients, the end users of all of our services.

Some may consider the giving up of participation in CME by some of the top experts to be acceptable. I respectfully disagree. Others would say that the top experts don’t work with FDA-regulated industry and that is why we must focus only on financial relationships with FDA-regulated industry. But, again, I have to disagree. Pfizer’s success, much like the success of all of the other “industries” in healthcare—for example, academic medicine—depends on working with the very best experts, whether within or outside of our organization. The same would hold true for the CME industry.

While asking ourselves these CME-related questions, we might also ask ourselves how we achieve objectives of collective benefit and keep the kind of thinking described here from seeping into and affecting other areas of potential collaboration and partnership. After all, that is how bias works. It is built on prejudice and uneven application of standards, and thus few reliable ways exist to stop it from spreading.

A worrisome trend promotes the thinking that FDA-regulated industry and those who work with it cannot or should not be trusted as partners in addressing medical education and healthcare system needs. The effects of this trend are already visible. Some institutions are introducing policies that exclude from CME faculty positions staff members who conduct clinical research involving pharmaceutical companies in any way, or if their participation is not prohibited, at least it is discouraged.

In this environment these experts can either conduct research and expand the boundaries of human knowledge, or they can share their existing knowledge in CME. But it is increasingly difficult for them to do both. This situation further excludes leading experts from participating in CME and further restricts the best possible flow of scientific and clinical thinking in education.

SUMMARY

Returning to the larger picture, for all of the intellectual horsepower working in CME, and for all of the great scientific minds working throughout our healthcare system, there is something chillingly unscientific about the perception and treatment of the pharmaceutical industry in both CME and healthcare on the whole:

- First, much greater energy is devoted to revealing conflicts of interest than to pursuing our enormous confluence of interest in improving patient care through the sharing of scientific and clinical information.

- Second, applying this focus on conflict only to the pharmaceutical industry will only serve to isolate one of the greatest producers and repositories of scientific and medical information in the world from those who could benefit from it the most: physicians and their patients.

- Third, partitioning those who work with the FDA-regulated industry from those who work on CME—by use of what is effectively a form of industrial profiling—not only works against industry/provider collaboration in CME but also hinders our ability to act as partners in addressing the larger healthcare issues the United States faces today by perpetuating ill-founded stereotypes and generalizations regarding the pharmaceutical industry. The very magnitude of the transformation required to reform our healthcare system argues against excluding any group that might be able to help with this task.

Does CME need pharmaceutical industry funding to survive? The answer to that is unknown. But the treatment of FDA-regulated industry is taxing the very desire to provide this funding. The greatest value of CME rests on the free flow of the best scientific and medical information possible. Whether the pharmaceutical industry funds CME at today’s levels or not, we must make our
stand on the bedrock of free scientific speech, always promoting protection of the unimpeded movement of credible information as the ultimate CME strategy, upon which all others must be built for survival in today’s environment.

Science and its power to inform better patient care must prevail over bias against industry and over bias against its role in improving the broader US healthcare enterprise. Here are a few suggestions for how we might help science prevail in CME and beyond:

• Apply conflict of interest standards consistently, requiring 100% disclosure of all financial conflicts and other possible nonfinancial conflicts. Let’s have simple rules that apply to everyone involved in CME.

• Improve accountability across the system by enforcing rules against accreditation violations.

• Increase transparency of the system by requiring all CME providers to post their CME policies online.

• Whenever possible and practical, require full peer review of all CME programs and materials.

CONCLUSIONS

Conflicts of interest can always be found by those who look hard enough, but for the sake of patients and the healthcare delivery system that serves them, more time and energy must be devoted to looking for the confluences of interest between CME and the pharmaceutical industry. The greatest of these confluences is a shared interest in information, objective, insightful, and timely scientific and medical information that expands our awareness, increases our options, and advances the cause of quality healthcare.

Recognition of shared goals and interests is crucial, because just as the success of CME depends on the free movement of the best information available, so too does our ability to shape a healthier US healthcare system. We must work together to ensure that science—in the form of the free movement of the best information available—does prevail.

REFERENCES