Two views of CME

CME and the pharmaceutical industry: two worlds, three views, four steps

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Imagine you have following two courses to choose from. Course A is a 3-day event sponsored by ABCPharma. Called Diabetes Today, it is a series of lectures held at an upscale resort. Registration is only $125, the accommodation fee is sizably reduced, and the course promises to provide a much-needed break from practice. Course B is sponsored by "McRonto University" (the new medical school in Oakville, Ont.) and will be held at a reasonably priced hotel in town. It costs $325 for two and a half days, plus full-fare accommodation. The topic — managing diabetic patients with comorbidities — will be covered in multiple formats, including case-based workshops.

The choice should be fairly easy: course B, given its better format, more clearly defined objectives and apparent freedom from the influence of the pharmaceutical industry, easily trumps course A — at least in the mind of the ethical, self-directed, evidence-based physician.

Or does it?

The role of "big pharma" in continuing medical education (CME) is undoubtedly one of the major professional issues in medicine today. Let us approach it from three different vantage points: that of the pharmaceutical industry, of medical schools, and of physicians and their patients.

"Big pharma" involvement in CME is a mixed picture. On the one hand, the pharmaceutical industry has its own interests — it's a business, after all — and there are lots of examples of so-called educational events whose real objective is to change prescribing behaviour.[1,2] On the other hand, a code of marketing practices does exist,[3] many pharmaceutical companies are scrupulous about distinguishing between CME and promotion, and — at the end of the day — many discoveries that extend lives and reduce suffering are made in the research departments of pharmaceutical companies.

Now for the involvement of medical schools. The role of an ethical provider of CME such as "McRonto University" is, to a greater extent than one might imagine, a mixed picture of pharmaceutical and nonindustry funding. Although separate data do not exist for Canadian schools, the biannual survey of the Society for Academic Continuing Medical Education[4] captures data from the United States and Canada. This survey reflects a growing trend among medical-school providers of CME: over the period 1993–2001, while medical schools reported a modest 25% increase in the number of courses and a doubling of registration fees, they disclosed a *quintupling* of commercial support for CME. Does this matter? Does increased industry funding necessarily lead to bias in medical-school CME?

Research indicates that industry funding can skew CME content in various ways to match the goals of industry.[2,5,6] This skewing may be felt in the subtle influence of industry on the selection of topics (do medical-school CME curricula devote as much time to the *diagnosis* of hypertension as it does to its *treatment*?) or, at a more general level, in what receives support and what does not (courses on social pathologies are less common than those, say, on diseases with specifically "medical" management). Given that the primary driver of physicians' involvement in CME is an interest in their patients' welfare, and that the main interest of industry is to promote profitability,[7,8] increased industry funding of CME raises many questions, among them: What can we do about a possible skewing effect? Need we do anything?

Here we come to the third vantage point. In determining the appropriate boundaries between the pharmaceutical industry and medical schools and, by extrapolation, between industry and CME more globally, we must not forget what CME is all about: physician-learners and their patients. This vantage point must inform the steps we take to ensure that physicians make informed decisions about CME. In that vein, let us take the following steps:

1. *Increase the decision-making capacity of physicians.* We need to assure ourselves that physicians have adequate undergraduate, postgraduate and continuing training in critical appraisal and ethical decision-making. This assurance implies both teaching and testing. Let's do both. Let's do them better.
2. *Broaden the definition of "full disclosure."* It may not be enough to ask the physician-speaker to "disclose" industry connections at the beginning of a talk. All CME providers, medical school and industry included, might consider indicating the full amount that industry (*and* other sources) have contributed to programming, so that physician-learners can discern the degree of pharmaceutical or other support. This is not a new concept.[9]
3. *Level the playing field.* Some have called for greater government and professional support for continuing pro-

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fessional development, to balance the influence of industry.[10] Although support from these quarters also has the potential to introduce bias, the diversification of funding sources has in fact begun: the support of the Ontario Ministry of Health and Long-Term Care and of the Ontario Medical Association for the Guidelines Advisory Committee[11] is an example, as is the federal government's Primary Health Care Transition Fund[12] initiative with the Association of Canadian Medical Colleges. This could be just the beginning.

4. *Organize dialogue, develop guidelines, give the process legs and teeth.* Who will continue the dialogue, and how? Who will develop Canada-wide guidelines and see to their application? Although guidelines do exist at the local level (the University of Toronto's are arguably the most stringent in the country[13]) and overall accreditation guidelines are in place,[14] there is wide variability in their application. Clearly, we need a national body to take on the challenge of containing, examining and regulating the issues for all Canadian health care such as the Committee on Accreditation for Continuing Medical Education (a collaborative accreditation process of the Canadian Medical Association), the Association of Canadian Medical Colleges, the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada, among other groups.

Are there more steps to take in the process? Of course. But if we want physicians to have the necessary information, skills and confidence to make informed decisions (for example, in choosing between course A and B), and thus to be better able to balance learning needs and patient concerns, these four action items might be a start.

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Competing interests: Dr. Davis has provided advice to and has spoken at events sponsored by pharmaceutical companies. He has adjudicated in one case involving a possible abuse of CME guidelines, and he is the chair of the Ontario Guidelines Advisory Committee. He uses honoraria generated from industry activities to support the Academic Development Fund in Continuing Education at the University of Toronto.

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The future sponsorship of CME in Canada: Industry, government, physicians or a blend?

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A recent editorial in *CMAJ*[1] pointed out that continuing medical education (CME) programs financed by pharmaceutical companies can present information in a biased manner — that, in effect, some of these are thinly disguised efforts to market products. The editorial questioned the roles of professional associations — including the College of Family Physicians of Canada — in providing oversight of CME content offered for educational credit. Certainly, there is evidence that the pharmaceutical industry can influence physician prescribing through marketing and educational efforts.[2–5] In addition, many "unrestricted grants" from commercial sponsors focus on programs that cover an area of practice related to the donor's products, leaving many "orphan" topics that attract no financial support. Yet the fact remains that the pharmaceutical industry in Canada has been a major con-