Industry Support of CME — Are We at the Tipping Point?

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In the 1970s and 1980s, industry-sponsored junkets for physicians, thinly disguised as educational events, were common. Increasing public scrutiny and the threat of government regulation and legal action led physicians’ organizations and the pharmaceutical industry to adopt increasingly restrictive codes of conduct related to industry support of continuing medical education (CME). The Accreditation Council for Continuing Medical Education (ACCME), which accredits CME providers, progressively developed an aggressive system of identifying, disclosing, and resolving conflicts of interest.

Despite these increasing restrictions, industry support for CME grew substantially between 1998 and 2007, from $301 million to $1.2 billion per year (see graph). By 2007, industry support accounted for 48% of the revenue of accredited CME providers (not including advertising and exhibit payments, which accounted for an additional 11% of total revenue). In the past few years, however, the tides have started to shift. Commercial support for CME started to decline in 2008, and by 2010 it was down 31% from its peak 3 years earlier. Over a similar period, a series of influential reports and policy papers have recommended major new restrictions on industry funding, with some proposing the complete elimination of industry support for CME. Several academic medical centers have adopted stringent restrictions on conflicts of interest for speakers and in some cases required that industry funds be directed to a central funding pool divorced from individual programs. Other institutions have gone further and completely prohibited industry support of their CME programs. Twenty percent of accredited CME providers and 80% of accredited CME activities (including grand rounds programs) did not receive any commercial support in 2010.

New rules under “sunshine” provisions of the 2010 health care reform legislation may require extensive disclosure reporting for speakers and learners in commercially supported CME activities, creating an additional roadblock for industry support. Perhaps most strikingly of all, the House of Delegates of the American Medical Association (AMA) recently approved an opinion from the AMA Council on Ethical and Judicial Affairs that “when possible,” CME activities should be developed without industry support and without the participation of teachers or program planners who have financial interests in the subject matter. The new policy defines circumstances that allow continued industry support and the involvement of conflicted experts. It was passed only after more restrictive language that was present in four previous, unsuccessful proposals had been watered down. Nonetheless, this policy is important
because the AMA represents a mainstream voice in U.S. medicine. The passage of the policy signals broader acceptance of a restrictive approach to CME funding that has historically been at the margins.

We may thus have reached a tipping point: the slow, uphill progress in limiting industry involvement appears to be accelerating, and further restrictions are likely to become more widespread. These changes did not arise from one or two events. Rather, they resulted from shifting norms in the culture of medicine. It is doubtful that all industry involvement with CME will cease in the near future, and the recent decline in industry support may also reflect difficult economic times. However, we appear to be entering a new era in which earlier norms of acceptability no longer apply.

What effects will changes in CME funding have on continuing education for physicians? Those who endorse ongoing industry support argue that more stringent regulation will have negative effects on the availability, quality, and cost of CME. Although reducing reliance on industry funds will not be painless, it remains highly feasible to do so in a manner that preserves (and in some ways enhances) access and quality. Costs can be substantially reduced by avoiding high-priced venues such as the hotel conference spaces where CME events are often held. When Memorial Sloan-Kettering decided to forgo all industry support for its CME programs, it started holding its events in medical center facilities. Moreover, CME providers are de-emphasizing traditional lecture-hall–based teaching in favor of more interactive, interprofessional, and competency-based learning strategies. Such strategies include online teaching tools, point-of-care CME, and performance-improvement CME, which not only offer pedagogical value but in many cases can also be provided at relatively low cost. This trend is likely to continue as CME is increasingly linked to practice-improvement and maintenance-of-certification processes that require explicit practice-based learning.

Another source of concern for some observers is losing the contributions of experts whose participation in CME would be restricted because of their financial conflicts of interest. It is worth remembering, however, the examples of some journals and professional medical organizations that have successfully solicited editorials and developed clinical-practice guidelines despite having strong policies limiting the participation of people with conflicts of interest. In addition, removing the financial conflicts of interest of CME providers will probably yield a more balanced mix of content, since the existing system provides incentives for developing symposia focused on drug therapy so as to attract industry sponsors.

Although increased restrictions on industry support are likely to have beneficial effects for accredited CME, unintended consequences are also likely. To the extent that industry funding for CME is squeezed, industry is likely to channel its energy and money into other venues, as it did when gifts from pharmaceutical sales representatives were restricted. The effect may be like that of squeezing a balloon: if you clamp down on one side, another side will pop out. Reducing industry funding of CME may also result in increases in nonaccredited medical education, such as dinner lectures at restaurants and satellite symposia at professional society meetings. Such events are often sponsored directly by drug manufacturers and need not abide by the ACCME’s and CME providers’ regulations governing conflicts of interest and balance of content.

If changes in the CME landscape drive physicians away from accredited events toward these nonaccredited activities, the overall state of medical education will not have improved. Industry may also be driven to redouble its efforts to influence professional societies, policymakers, and opinion
leaders, all of whom can have major downstream effects on the practice of individual physicians. Thus, efforts to regulate CME should not be made in isolation from the myriad other ways in which industry interacts with and influences physicians and institutions. Careful attempts to reach across the silos of education, research, and clinical practice could lead to a more coherent set of policies and help to avert unintended adverse consequences.

Although industry support for accredited CME is unlikely to disappear entirely in the near future, a sea change toward greater restriction is beginning to happen as a result of cultural, regulatory, and economic changes — and a few courageous acts. CME and health care will be better for it. The question for both supporters and opponents of greater restriction is not whether we should institute these changes — that train has already left the station — but how to maximize the benefits of these changes and avoid unintended consequences in other aspects of physician–industry relations.

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Directions for Bipartisan Medicare Reform

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Before Senator Ron Wyden (D-OR) and Representative Paul Ryan (R-WI) introduced their “Bipartisan Options for the Future” on December 15, 2011, the notion that Democrats and Republicans agreed about certain aspects of Medicare might have seemed unthinkable. But the pairing of a liberal Democrat who has long worked on health care reforms and a fiscally conservative Republican primarily known for work on budget issues suggests that it might be possible for the parties to reach a compromise on Medicare reform. Of course, meaningful reform is not likely to occur in 2012: any significant reform probably won’t happen until the public sends a clearer signal about the kinds of change it will tolerate, which won’t be possible until after the fall elections. Yet some Republicans and Democrats appear to be in substantial agreement about some changes that might make Medicare more efficient, effective, and fiscally sustainable — even if none of these changes are universally accepted by either party as desirable or even tolerable.

First, there has long been discussion about raising Medicare’s eligibility age from 65 to 67, as is happening with Social Security. Though still controversial among some Democrats, this policy change was put on the table by President Barack Obama as part of a compromise package. With 78 million baby boomers becoming Medicare-eligible over the next 18 years, eventually doubling the number of beneficiaries, increased spending due to population aging and greater longevity is making such a change seem more compelling.

As opponents note, however, the savings from increasing the eligibility age by 2 years probably wouldn’t be large, since the youngest seniors tend to be the healthiest. Moreover, if Medicare doesn’t cover them, 65- and 66-year-olds will need to continue working to get coverage from employers (which, it could be argued, would be better for them and for the economy, assuming that the economy improves enough to generate the jobs needed) or they will get subsidized coverage from the health insurance exchanges being created by the Affordable Care Act (ACA). The effect of such a change on overall spending has been debated, but the effect on federal spending is likely to be favorable.

Second, despite past controver-