Pharmaceutical industry support for continuing medical education: Is it time to disengage?
Ian H Kerridge (2011)

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Over the past two decades, the relationship between the medical profession and the pharmaceutical industry has been a source of intense debate, largely because of concern that it may harm patients through inappropriate prescribing, increase the costs of health care through the unjustified use of expensive pharmaceuticals and ultimately subvert the (proper) goals of medicine, medical education and medical research.1–4 Recent well-publicised instances of companies using multiple means, including continuing medical education (CME), to promote off-label use of their drugs (including AstraZeneca, which paid US$520 million in 2010 to settle charges that it promoted unapproved use of the antipsychotic quetiapine, and Eli Lilly, which paid US$1.415 billion in 2009 in criminal and civil penalties for promoting off-label use of olanzapine) have only served to heighten concerns that doctors can be persuaded, through direct or indirect means, to further the commercial interest of the pharmaceutical industry.5

It is uncertain exactly how much money the pharmaceutical industry spends on promoting its products to medical practitioners through detailing, advertising, gifts and drug samples, and support for travel, scientific meetings and continuing medical education. But it is a very large amount – a recent estimate put it at more than $US50 billion per year in the United States alone, with at least $US1–2 billion being spent on CME – and it is effective.6

The available literature concerning the relationship between the pharmaceutical industry and the medical profession is remarkably consistent; doctors (and medical students) are influenced by contact with industry (in all its forms) but believe (wrongly) that they are not and/or that they are able to detect bias and influence.7–9 And while there is limited direct evidence regarding the harms resulting from industry support of CME, there is some evidence that it may influence knowledge, attitudes and prescribing behaviour and substantial evidence that industry-sponsored CME activities are more focussed on drug therapies and are more favourable to company products than programs not funded by industry, and so may be linked to both adverse patient outcomes and increased health care costs.10 Additional research also suggests that the financial ties that bind industry and health professionals also threaten the trust the general public has in doctors and in medicine more generally.11

In response to such concerns, over the past decade, professional and industry codes in the United States, the United Kingdom, Australia and elsewhere have moved to restrict interactions between the pharmaceutical industry and medical profession, or at least demand that they become more
transparent. Increasingly, doctors are expected to declare links with industry whenever they write or speak in public. Companies must disclose the amount they spend on marketing and consultancy and promotional items, such as coffee cups, diaries and stationary are either banned altogether or labelled with company logos/names but not the name of specific drugs.12

The same changes are evident in relation to CME, with industry, professional college and association guidelines all calling for greater transparency and distance where the pharmaceutical and biomedical technology industry are involved in supporting CME. In the United States, recent reports by the Josiah Macy Jr Foundation, the Institute of Medicine, the American Medical Association (AMA) Council on Ethical and Judicial Affairs and the Association of American Medical Colleges have all called for the establishment of independent CME that either operates completely at arm’s length to industry or receives no commercial support at all.10,13–16

Medical schools, likewise, particularly in North America, are creating new, more restrictive policies to guide the relationship between academia and industry.17 In 2009, Harvard Medical School moved to obligate academic staff to disclose their industry ties to students in class, restrict the amount of money that staff members can earn from pharmaceutical or biotechnology companies and make financial ties between staff and industry more transparent following intense political, public and student scrutiny of the extent of ties between industry and the medical school (in 2008 pharmaceutical companies had contributed US$8.6 million to Harvard for basic research and US$3 million for continuing education).17

But while professional codes of ethics and industry codes of practice increasingly share common ground, some would argue that these incremental improvements in the regulation of the relationship between doctors and the drug industry are largely cosmetic. They can cite the relatively small fines that can be imposed upon industry (particularly in Australia), the aggregation of marketing data such that there is no obligation to name individual recipients of funding or to have these relationships publicly known and the persistence of promotional activity under the guise of education.

Given what we know about the impact of industry funding on knowledge, attitudes and prescribing behaviour, the costs of pharmacotherapies, the (increasing) difficulty that people have in affording their basic medicines, the fundamental impossibility of clearly separating education from promotion/marketing (given that both seek to create influence) and the limited capacity of any ‘firewall’ to eliminate the potential for bias, one must ask whether the time has come to abandon the commitment to strategies based upon disclosure and management of the relationship between industry and the medical profession and move to strategies based upon divestment and separation.13,18 While this may not be possible, or even logical, in the research setting given that all drugs are developed by industry, it would seem both possible, and logical, in the setting of undergraduate, postgraduate and continuing medical education.19

This does not mean that we should see the pharmaceutical industry as ‘evil’, for indeed there is nothing inherently wrong with the promotion of commercial goods in capitalist economies and retreat to polemic serves no purpose at all. Nor does it mean that medical practitioners and researchers should have no contact with industry at all. Rather, we should simply ask ourselves whether all aspects of the existing relationship with industry are necessary or appropriate and whether it is possible to construct relationships with industry that is productive, which supports drug discovery and development and that is professional, publicly defensible and ethically robust.

In this regard, it is important to note that defenders of industry sponsorship of medical education generally do not argue that it is desirable, rather that it is necessary and/or unavoidable and can be properly managed to benefit both physicians and their patients. But is this true?

As Howard Brody has noted, many of the ethical tensions that arise from interactions between the pharmaceutical industry and the medical profession are matters of choice rather than necessity.
Physicians do not need lavish accommodation or free meals at scientific meetings, do not need travel expenses paid in order to attend conferences, do not need to attend industry-sponsored symposia in order to get reliable, valid and peer-reviewed information about new or established pharmacotherapies, do not need to accept generous honoraria to become industry consultants or members of advisory boards, do not need to attend meetings in expensive hotel venues, and do not need to accept promotional/educational material provided by detailers and at sponsored meetings and conferences.20

Alternative sources of appropriate support for continuing education and sponsorship for scientific meetings could also be found that do not create the same threat to rational prescribing. Clinicians could pay for their own education, health care institutions, and employers could be asked to accept that a greater proportion of their budget be allocated to support the continuing professional education of their employees, and industries unconnected to health care, such as the travel or real estate industry, car manufacturers, IT providers, office suppliers and the like, approached to support academic meetings.21,22

Alternative means for delivering education, including use of mobile phones, the new social media and the internet, may also be better utilised. They might, in any case, be more efficient, more clearly link to ongoing education and assessment, and, particularly in light of the enormous carbon footprint associated with international and domestic meetings, ultimately be more environmentally responsible and sustainable (surely something that would appeal to the modern physician interested in global health).

While the loss of industry support may involve higher costs for physicians and require cost cutting by education providers, there is good reason to believe that CME would survive and prosper despite the loss of industry sponsorship and that many of the costs of CME could be reduced without sacrificing quality at all.16,23,24

But any change to the culture of expectation that permeates medicine and CME will not be easy. At least in the short term, as industry sponsorship is phased out, doctors may have to consider paying higher registration fees for academic meetings and conferences, and may have to accept that meetings will be held at less expensive venues and locations – something that many practitioners may find unappealing. (In this regard, the results of US and Scottish studies are noteworthy in that both found that doctors recognise that commercial sponsorship of CME introduces bias but that less than 50% would be willing to pay increased registration fees in order to reduce or eliminate commercial support.25–27) But change may be possible. Already some major institutions, including the Memorial Sloan Kettering Cancer Center, New York, and the University of Michigan, Ann Arbor, have moved successfully to models for CME that do not rely upon commercial support.28

In contrast to the research context, where interaction between physicians and industry is inevitable and unavoidable and thus must be effectively managed, in the educational setting it is neither inevitable nor unavoidable and may be effectively replaced by different models for funding and delivering medical education. To continue to accept or to demand industry support for education, where alternatives exist would seem, as others have argued, to be both imprudent and ethically questionable.29 It is time, therefore, to develop and support approaches to CME that provide high-quality education without undue influence and without adding to costs of pharmacotherapies that are ultimately borne by patients and by the health system.30,31

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