Addressing bias in industry-funded CME

How can you afford CME without industry money? Tip: don’t host programs at venues that look like this.

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Emails describing continuing medical education (CME) programs pop up on Dr. Brian Gilfix’s computer all the time, and though industry sponsorship of CME is not uncommon, there were several things about a program description that recently crossed his inbox that stuck him as rather egregious.

The program was about testing for metal hypersensitivity, a controversial subject, says Gilfix, an associate professor of medicine at McGill University in Montréal. Yet the document he was reading lacked balance; it appeared closer to promotion than education. Furthermore, if you clicked on the URLs listed under “resources,” you were taken to corporate websites, where you learn that the cost of testing starts at $450 and it isn’t covered under provincial insurance plans.

“They had direct links to the testing company, and that company had a proprietary test; that struck me as a bit much,” says Gilfix.
Pharmaceutical companies and providers of medical devices and tests influence the practice of medicine in many ways. There is much money to be made and conflicts of interest abound, a situation that is often accepted, if begrudgingly, and somewhat controlled by disclosure rules and processes to reduce bias.

Some physicians, however, feel the continuing education of doctors is too important to be influenced by the bias, overt or subtle, that inevitably creeps into programs sponsored by industry. The Canadian Medical Association faced criticism, for example, when it teamed with Pfizer Canada Inc. to create an online CME program in 2009.

Yes, someone has to pay for the programs. But critics suggest that until other sources of funding are found, industry-funded CME will continue to focus too much on some topics, like prescribing brand-name drugs, and too little on other subjects, like dietary and lifestyle interventions, generic medications or how to improve communication in medical practices.

“When a conference is sponsored by pharmaceutical industries with direct funding, they tend to focus only on health conditions that have a new drug coming out for that health condition,” says Dr. Sheryl Spithoff. “A lot of other topics get ignored. I think that is a huge issue.”

In a recent editorial in Canadian Family Physician, Spithoff, who practises family and addiction medicine at Women’s College Hospital in Toronto, explained some of the other problems of industry involvement in CME. For example, it places CME organizers under pressure to create content and choose speakers that will attract industry funding. The benefits of a sponsor’s product will likely be trumpeted, its risks likely downplayed. Pharmaceutical sponsorship has also been linked to poorer prescribing habits, including nonadherence to guidelines and overprescribing of expensive, brand-name drugs.

Spithoff cites the sponsorship of more than 20 000 educational programs for the opioid OxyContin as a cautionary tale. Sales of the drug in the United States grew from $48 million in 1996 to almost $1.1 billion by 2000, but the risks of addiction and abuse were misrepresented in educational material for physicians, writes Spithoff, which resulted in a “commercial triumph, public health tragedy” story.

Many physicians give little thought to the pitfalls of industry sponsorship, though, because the practice is so ingrained in how CME is delivered in Canada,
says Spithoff. Early in her medical career, she did not question it much herself, until a residency supervisor brought the issue to her attention. She now views it as a topic of great importance, because continuing education is so vital to practicing medicine well.

“The medical field isn’t static; it is constantly changing. There are new developments all the time,” she says. “If you stopped learning after residency, you would be completely out of date in five or 10 years, probably even before that.”

Canada is not, of course, the only country dealing with this issue. In the United States, industry support for CME grew from $301 million to $1.2 billion between 1998 and 2007, according to a paper in the New England Journal of Medicine. Industry sponsorship appears to have peaked around 2007, however, and declined by 31% by 2010. This has been attributed, in part, to increased scrutiny on the practice, which lead to increased restrictions on conflicts of interest at some US institutions that offer CME and, in several cases, outright bans on industry funding.

“There is still a tonne of money sloshing around, though,” says Dr. Michael Steinman, an associate professor of medicine at the University of California, San Francisco, and the paper’s lead author.

In an editorial in Canadian Family Physician, Steinman argued that drug companies view medical education as an important part of their strategies to increase sales. And though this goal may not be shared by providers of CME, the financial dependency on industry can have “subtle yet strong effects” on the objectivity of educational programs.

“It’s not because people are bad, and it’s not because people are trying to cheat the system,” says Steinman. “It’s just that the structure is set up to highly facilitate that we go down a certain path that is typically more favourable to one drug or device being presented as opposed to another because we have these financial incentives steering things in that direction.”

In her editorial, Spithoff makes a number of suggestions to lessen industry influence on CME. Ideally, it should be banned, she writes, but at very least it should be limited. That could be accomplished by permitting companies to contribute only to an unrestricted pool rather than to individual sessions. She also recommends that the bodies that accredit CME programs, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of
Canada, implement 5-year plans to only accredit sessions that have received no money from industry. Moving toward prohibiting physicians with financial ties to industry from planning or teaching CME would also be a step in the right direction, writes Spithoff.

Alternate sources of funding suggested for CME include increased fees for physicians, a tax on the pharmaceutical and medical device industries specifically to fund physician education, and money from the public health care system, which might actually benefit from lessening industry’s influence on medical practice though reduced spending on brand-name drugs.

According to Steinman, industry influence could be mitigated if CME providers went beyond minimum accreditation standards. They could, for instance, decline to offer events sponsored by a single company. As for how to pay for CME, minimizing costs would be a good place to start, says Steinman. “You can convene a CME conference in a hospital or university facility where you can get an auditorium or conference room at low or no cost, as opposed to doing it in a fancy hotel.”

Coming soon Part II: CME accreditation: separating education from promotion