CME on the cusp of change

The quality of patient care reflects the performance of doctors, nurses and associated healthcare professionals. Their performance depends not only on clinical competence but also on behavioural factors related to ambition, integrity, ethical considerations, career advancement, age, well-being and healthcare infrastructure. To optimise these various elements of medical performance, most advanced countries subscribe to the concept of continuing professional development (CPD) of which the main tool is continuing medical education (CME). The providers of most European CME are the national and European medical specialist societies, hospitals/local employers, government health departments and commercial companies. There is also an emergent "CME provider" community that develops education under strictly observed ethical rules (as typified by members of the Good CME Practice group1 and BMJ Learning).

This all sounds sensible and straightforward, but there is an elephant in the room in the form of the drugs and devices industry. Arguably this industry has contributed more to improving medical care than anything else and in addition has supported medical education over the years. The Merck Manual published since 1899 is the world's best-selling medical text book.3 But, the industry's success has depended on persuading the medical profession to use its products. Previously, this was achieved by simple marketing, often unashamedly partisan with not even a pretence of objectivity or balance. This meant that patients were offered not only good new drugs but also bad new drugs and good ones to be used badly.

In an attempt to become more respectable in an increasingly critical environment, the industry has shifted its emphasis from promotion to education. It has paid generous honoraria to "key opinion leaders"; it funds educational events at which its products will be favourably reviewed by experts in receipt of consultancy fees; it arranges meetings to discuss drug trials which it has devised, safe in the knowledge that the data will not be inimical to its interests (industry-sponsored trials report more favourable results than non-sponsored trials4). In 2012, pharmaceutical companies in the United Kingdom paid individual doctors and healthcare professionals a total of £40 m for a range of services such as consultancy, presentations on their products and sponsorship to attend educational conferences.5 In Europe, the major providers of CME-CPD are the European specialist societies, and their income depends predominantly on their annual congresses which are mainly funded by the industry. It is hypocritical of doctors to denounce the industry for these practices with which most of their colleagues have been complicit.

In an attempt to remove commercial bias from CME, most European countries have established national accreditation authorities to which providers must submit their proposed educational activities for approval. In the United States, this function is carried out predominantly by the Accreditation Council for CME (ACCME), and in Europe, the leading pan-European accreditor is the European Accreditation Council for CME (EACCME). However, discontent has rumbled on. In the United States, the Senate Finance Committee published a report in 20076 which criticised the ACCME for not being rigorous...
enough in excluding commercial influence on CME. They noted that data examined by the ACCME to decide on accreditation were supplied solely by the provider and the ACCME made no attempt directly to assess educational activities. Withdrawal of accreditation from non-compliant providers was said to be extremely slow. The ACCME responded by applying its criteria more stringently, particularly in relation to industry sponsorship and dealt with recidivists more promptly. In Europe, the EACCME has published new criteria for accreditation of both live events and e-learning, and these are regarded by many providers as being unduly inimical to industry and unnecessarily bureaucratic.

Further control on industry-supported CME has been energetically imposed since 2006 by the US Foreign Corrupt Practices Act (FCPA) of 1977 which prohibits bribery in foreign countries by American firms. If a subsidiary of a US drug or device company operating in a foreign country breaks this law, the parent company in the United States is liable to prosecution. Similarly, a European company with a US division can be prosecuted under US law. In 2012, GlaxoSmithKline (GSK) agreed to pay $3 billion and pleaded guilty to criminal charges in the United States that it had illegally promoted drugs and withheld drug-safety data from regulators.

The past year saw the implementation in the United States of the Physician Payment Sunshine Act (2010), part of the Healthcare Reform bill which requires all transfers of value, usually money, between the industry and doctors to be publicly disclosed. Following representation by the ACCME that compliance with its Standards for Commercial Support excludes the possibility of commercial control of educational programmes, the delivery of accredited CME has been exempted from the need for such disclosure.

The wind of change has now crossed the Atlantic. Ben Goldacre, a trenchant critic of the industry observed, “academic research has repeatedly shown that doctors who receive money from industry have biased views about which treatment works best.” In 2010, the UK Bribery Act was passed, and in 2011, AstraZeneca became the first major company to end payment to doctors for travel to international meetings. In 2013 GSK said it will end the practice of paying doctors to speak about its products and will stop sponsoring healthcare professionals to attend conferences by the start of 2016.

Perhaps in response to the US Sunshine Act, in June 2013, the European Federation of Pharmaceutical Industries and Associations (EFPIA) published a code on disclosure of transfers of value from pharmaceutical companies to healthcare professionals and organisations. All financial transactions in Europe between companies and doctors must be publicly disclosed in a transparent way and it is expected that the code will become operative in 2016. In Europe, there is no exemption in relation to accredited CME, because there is no European organisation, equivalent to the ACCME, which could provide a similar guarantee about lack of commercial bias in relation to national and European CME.

The level of financial support for CME by the industry will diminish because of the cumulative effects of EFPIA, the UK Bribery Act, FCPA, the Sunshine Act and the perception by industry of increasingly hostile accreditation agencies. This is likely to reduce attendance and participation in the annual European specialist medical congresses, and the consequent impoverishment of the European societies will compromise their overall CME provision. Many European conferences may become unviable. As a result fewer doctors will benefit from CME both at annual congresses and at other smaller European specialist society events throughout the year.

The direction of travel suggests that eventually doctors will have to fund their own CME which in some ways would be quite liberating because it would remove the suspicion of industry bias. Long overdue importance could be restored to diagnostic skills, clinical investigation and non-drug-related management. However, the decline of the international congresses will render doctors more insular. The new order will also diminish contact between doctors and the industry which will have to find new ways of advertising its wares. This could be achieved by an independent third party. One candidate for this would be the European Medicines Agency (EMA), an agency of the European Union, based in London, which currently is mainly concerned with patient safety in relation to drug treatment. Its activities could be increased to include the organisation of randomised new drug trials, comparison of similar drugs, long-term pharmaco-vigilance and publication of clinical guidelines. The drugs and devices industry would therefore deal with the EMA rather than with practising doctors, a relationship in which both have often behaved badly.

All these recent developments strongly indicate that the future relationship between the industry and the medical profession will change and in that process of change, CME will be affected. Who knows whether for good or ill? This editorial seeks only to stimulate discussion on this topic in the hope that wise decisions will be made and that the law of unintended consequences will not replace a flawed but workable system with one that serves doctors and patients less well.

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References

1. Farrow S, Gillgrass D, Pearlstone A, Torr J, Pozniak E, Good CME Practice Group. Setting CME standards in Europe: guiding principles for medical education. Curr Med Res Opin 2012;28:1861–1871.
2. BMJ Learning. Available at http://learning.bmj.com/learning/home.html, accessed January 6, 2015.
3. Merck Manual. Available at http://en.wikipedia.org/wiki/Merck_Manual_of_Diagnosis_and_Therapy, accessed January 6, 2015.
4. Lexchin J, Bero LA, Djulbegovic B, Clark O. Pharmaceutical industry sponsorship and research outcome and quality: systematic review. BMJ 2003;326:1167–1170.
5. Drug company payments to doctors. Available at http://www.theguardian.com/society/2013/apr/05/drug-companies-pay-doctors-40m, accessed January 6, 2015.
6. US Senate Committee on Finance. Committee staff report to the chairman and ranking member: use of educational grants by pharmaceutical manufacturers. Washington, DC: Government Printing Office; 2007.
7. Live events. Available at http://www.uems.net/__data/assets/pdf_file/0008/1205/UEMS_2012.30_Accreditation_of_Live_Educational_Events_by_EACCME__ADOPTED.pdf, accessed January 6, 2015.
8. e-Learning. Available at http://www.uems.net/__data/assets/pdf_file/0019/1198/UEMS_2011_20.pdf, accessed January 6, 2015.
9. Foreign Corrupt Practices Act. Available at http://www.justice.gov/criminal/fraud/fcpa/guide.pdf, accessed January 6, 2015.
10. The Physician Payment Sunshine Act. Available at http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-payment-Transparency-Program/index.html, accessed January 6, 2015.
11. Ben Goldacre interview. Available at http://www.theatlantic.com/health/archive/2013/02/what-the-sunshine-act-means-for-health-care-transparency/272926/, accessed January 6, 2015.
12. Kmietowicz Z. GSK is to stop paying doctors to talk about its drugs and attend conferences. BMJ 2013;347:f7579.
13. European Federation of Pharmaceutical Industries and Associations. Available at http://transparency.efpia.eu/the-efpia-code-2, accessed January 6, 2015.
14. European Medicines Agency. Available at http://www.ema.europa.eu/ema/, accessed January 6, 2015.