Panel: CME in Danger Without Industry Funding

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — Without pharmaceutical industry funding, continuing medical education is in danger of faltering, said a group of CME providers, several physicians, and a medical journal editor at a forum.

The forum—designed to educate Capitol Hill staffers—was sponsored by the Center for Medicine in the Public Interest, a New York–based nonprofit organization, and the Coalition for Healthcare Communication, an umbrella group for advertising agencies and medical journal publishers.

The meeting was called in response to numerous efforts from senators, House members, and accrediting organizations for greater accountability for CME funding. In July, a task force of the Association of American Medical Colleges said that academic medical centers should discourage faculty participation in industry-sponsored speakers bureaus. A month earlier, the Accreditation Council for Continuing Medical Education proposed tightening restrictions on commercial support of CME, and possibly even banning industry funding.

Panelists at the CMPI forum warned that withdrawing such funding would undermine a well-run and much-liked enterprise. "CME in the U.S. is a great success story," said Dr. George Lundberg, a former editor of JAMA and currently editor-in-chief at Medscape. CME changes knowledge, skills, and patient outcomes, he said, adding that surveys have shown that physicians are in favor of industry support.

Dr. Michael Weber, a professor of medicine at the State University of New York, Brooklyn, said that he views pharmaceutical company funding of CME as a mandate, "not a luxury." The manufacturers have a responsibility to educate clinicians on how to use their products, he said. The pressure for transparency is leading to what Dr. Weber called censorship. He said that he has had to alter presentations at the request of meeting leaders in this country, whereas a recent appearance at the European Society of Cardiology was completely within his control.

Another cardiologist speaking at the forum, Dr. Jack Lewin, said he had "serious, serious concerns about the recent attacks" on CME. Dr. Lewin, CEO of the American College of Cardiology, said that without industry funding, it would cost the ACC an additional $2,000-$3,000 per attendee at its annual meeting, for instance. The ACC has multiple steps to remove conflicts of interest from its professional and educational programs, he said. And, said Dr. Lewin, the ACC discloses its industry funding on its Web site.

About a third of that organization's $97 million annual budget comes from outside sources ($35 million), and 21% of that is from charitable contributions, he said.

Dr. Lewin said there had been abuses in the CME arena, but that the move to clamp down on those bad actors had professional societies and pharmaceutical companies running for cover, he said.

There is evidence to support his claim. Public Citizen's Health Research Group, in comments sent Sept. 12 to the ACCME on its proposal to limit or ban industry support of CME, said that, "Despite a quadrupling of commercial support for CME over the past 10 years, in 2007, the percentage of CME income provided by commercial interests actually decreased to 2002 levels." Public Citizen advocates an end to commercially funded CME. Because CME is a condition of licensure, demand will remain, according to the group. "Shifting the burden of funding toward physicians (not exactly a group occupying the lower rungs of the earning ladder) would attenuate the effect of lost revenue." ■

Drugmakers to Disclose Physician Pay

Two pharmaceutical companies will begin publicly disclosing how much each pays physicians.

Eli Lilly & Co. was the first company to step forward, followed a day later by Merck & Co.

Lilly is starting a registry that will compile payments to physicians who have served as speakers or advisers for the company. It will be available to the public on the company's Web site as early as the second half of 2009, Lilly officials said in a statement. The registry will be updated each year to reflect the previous year's payments.

The company said that by 2011, it aims to report whatever is required under the proposed Physician Payments Sunshine Act. That bill (S. 2029) was introduced by Sen. Chuck Grassley (R-Iowa) and Sen. Herb Kohl (D-Wis.) in November 2007. As currently written, it would require manufacturers of pharmaceuticals, medical devices, and biologics to disclose the amount of money they give to doctors through payments, gifts, honoraria, and travel. Product samples for patients would be excluded.

The bill was endorsed by several major drug companies, including Lilly and Merck, by the Pharmaceutical Research and Manufacturers of America, the Advanced Medical Technology Association, and by the Association of American Medical Colleges, among others. But it has not had any movement since its introduction.

In a statement, Sen. Kohl congratulated Lilly, saying the company was "fulfilling the obligations of the Physician Payments Sunshine Act before it has been enacted."

Merck said that beginning this month, it will disclose the grants to patient organizations, professional societies, and others for "independent professional education initiatives," which would include continuing medical education. Next year, it will include other grants made by the Merck Company Foundation and the Merck Office of Corporate Contributions. The information will be posted on its Web site.

Beginning in 2009, the company will also start disclosing payments to physicians on its speakers bureau.

Hospitals Are Slow to Offer EMR Subsidies to Physicians

BY MARY ELLEN SCHNEIDER
New York Bureau

The federal government's relaxation of self-referral and antikickback laws has had a "modest" effect in encouraging hospitals to subsidize physician purchases of electronic medical record systems, according to an analysis by the Center for Studying Health System Change.

Some hospitals are proceeding slowly, offering subsidies on electronic medical record (EMR) software to small groups of closely affiliated physicians, while other hospitals are offering only IT support services or extending their vendor discounts, according to the analysis of 24 hospitals. The analysis was funded by the Robert Wood Johnson Foundation.

In 2006, the Health and Human Services Department announced that it had created two safe harbors that would allow hospitals to subsidize up to 85% of the cost of EMR software and IT support services for physicians. For their part, physicians would be responsible for the full cost of the required hardware. The regulations are scheduled to sunset at the end of 2013.

The analysis by the Center for Studying Health System Change, which is based on in-depth interviews with executives at 24 hospitals, found that 11 of the 24 hospitals were considering offering some type of subsidy to physicians to help cover their EMR costs. The remaining 13 hospitals were not planning to provide direct subsidies to physicians, but some were considering extending their EMR vendor discounts or offering IT support services.

Hospitals that chose not to offer direct financial support to physicians had differing reasons. For example, some opposed the idea of offering EMR subsidies to physicians. Others said that granting access to vendor discounts was a sufficient incentive for physicians preparing to adopt EMRs. And other hospitals were interested in providing the financial subsidies directly to physicians but couldn't afford to do so.

For those hospital executives who were considering a direct subsidy to physicians, improving patient care and forging closer relationships with referring physicians were the top reasons cited for moving forward with EMR assistance. "Hospital executives expected physicians would be more likely to maintain, and even expand, their relationship with the hospital because of the improved efficiency from interoperability with the hospital's IT systems," the researchers wrote.

One factor that appears not to be driving the trend toward hospital subsidies is interest on the part of physicians. The arrangement has some potential drawbacks for physicians, according to the analysis.

For example, under the safe harbors physicians are still responsible for 15% of the software costs and 100% of the hardware costs associated with setting up the EMR system. Plus, physicians using the hospital-sponsored EMR may have difficulty storing records for patients who are treated at other hospitals where the physicians provide care for patients. Also, the hospital-sponsored EMR could serve as a barrier if physicians later wanted to switch their hospital affiliations, according to the analysis.

"While hospitals have strategic incentives to provide support, particularly to tie referring physicians to their institution, the effects of the regulatory changes on physician EMR adoption will ultimately depend both on hospitals' willingness to provide support and physicians' acceptance of hospital assistance," Joy M. Grossman, Ph.D., one of the study authors, said in a statement. ■

The study is available online at www.hschange.org/CONTENT/1015.

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