ACCME Standards for Commercial Support—Time for a Change?

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"The purpose of continuing medical education (CME) is to enhance the physician’s ability to care for patients. It is the responsibility of the accredited provider of a CME activity to assure that the activity is designed primarily for that purpose" (1).

Each year, all physicians participate as attendees or faculty in a variety of CME meetings. It may be medical or cardiac grand rounds at each institution, or it may be a one-day or several-day course sponsored by a variety of providers, including the American College of Cardiology (ACC). Institutions such as the ACC must be accredited in order to provide CME, which will count toward the requirements for relicensing. Although CME meetings are relatively common, it is still necessary for a physician to be sure to get his or her required number of hours per year. Many times, the attendee may travel to a vacation spot to combine CME with vacation. Alternatively, one might prefer a more intense experience all day, and sometimes into the night, to limit the time away from the practice. It is likely that all physicians understand that an organization like the ACC has to be accredited in order to provide CME. This is done by the Accreditation Council for Continuing Medical Education (ACCME). It is less likely that physicians understand the process involved in acquiring this accreditation or the standards for commercial support.

Because the pharmaceutical industry contributes considerable funding to CME courses, it is of great interest to review some of the standards governing that support. The current standards have been in place since 1992 and are now being studied with a view toward the probability that they will be updated. I recently served on a working group of the College to review the 1992 standards for commercial support and to make suggestions to the ACCME for potential change. Some of my thoughts about these standards for commercial support are listed below, particularly from the perspective of someone who has directed an ACC extramural program for 25 years.

As a program director, I must be sure that the program is free of commercial bias. When products are discussed, the information should be objective and based on scientific methods and trials. Generic names should be used, and speakers should give a balanced view of therapeutic alternatives. Potential conflicts of interest should be disclosed to the audience. I believe that this is done best when speakers show initial slides outlining their conflicts of interest (2). The content of slides and reference materials should be the responsibility of the speaker and should not, by either content or format, advance proprietary interests of a given pharmaceutical company. Neither exhibits nor sales activities should occur in the room(s) where presentations are being made. Funds originating from a commercial source should not be used for the travel, lodging, registration fees, honoraria, or personal expenses of non-faculty attendees. Selected scholarships for students, residents, or fellows may be appropriate. Payments of reasonable honoraria and expenses for faculty is appropriate, but they should be made through the CME provider and not made directly from the company. Thus, commercial support should be in the form of educational grants to the CME provider, such as the ACC. I believe that all of us would agree that the above guidelines are laudable and are intended to eliminate bias from the faculty presentations—or at the very least to alert the attendees to potential conflicts of interest of the speakers.

There are some difficulties with the current standards, however. When an unlabeled use of a drug is discussed, it is the responsibility of the faculty to let the audience know that the product is not labeled for that use. For example, if I were to discuss the potential benefit of amiodarone in the treatment of dilated cardiomyopathy, I would have to explicitly indicate that this was not a labeled use. The difficulty for speakers is that the approved uses of a drug are always changing and it is difficult to be sure what the labeled use might be at any given time. Furthermore, many drugs may still be useful in circumstances where they are not approved. I find compliance with this requirement of the standards to be difficult, if not impossible.

There have been widely divergent views on the role of commercial companies in providing funds for CME activities. Two recent back-to-back articles in the Journal of the American Medical Association illustrate this point. Dr. Arnold Relman flatly states, “The pharmaceutical industry has gone too far” (3). He believes that the ACCME standards are permissive and ambiguous. He provides arguments for eliminating most, if not all, pharmaceutical support and requiring physicians to pay the extra fees for CME. Although this is a laudable goal, physicians are currently complaining about the high cost of CME activities, even with pharmaceutical support. With physicians working harder and harder for less and less, this would be a particularly difficult time to substantially raise fees for CME activities. He attacks the assertion that companies are only...
after good will and not increased sales. On that point he is probably right.

The counterpoint article (4) is by Alan F. Holmer, JD, who is stating the viewpoint of the Pharmaceutical Research and Manufacturers of America. He points out that the pharmaceutical industry is proud to sponsor CME activities and that it serves a “mutual interest to ensure that patients receive the most up-to-date and appropriate care.” He indicates full support for the ACCME guidelines regarding commercial sponsorship. In a recent survey, he reports that 81% of responding physicians participate in CME to maintain state licensure requirements and that 42% asserted that their most important reason for attending was to keep up to date.

My own view is probably somewhere in between these two articles. An alliance between the pharmaceutical industry and organized cardiology has been a very positive thing in many ways, including sponsorship of fellowships, research funding (American Heart Association), and support for CME. With appropriate guidelines such as the ACCME guidelines, I believe that physicians can receive high-quality education with a minimum of commercial bias. Furthermore, physicians can generally recognize such bias when they see it. It will be interesting to see if the guidelines change substantially during this revision. For 10 years, however, I believe that they have served us well and will continue to do so in the future.

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REFERENCES