

REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-08)
Industry Support of Professional Education in Medicine
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

Objective: To provide ethical guidance for physicians and the profession with respect to industry support for professional education in medicine.

Methods: Literature review; ethical analysis of issues in professionalism raised by industry support for undergraduate, graduate, and continuing medical education; and feedback from key stakeholders within the AMA.

Results: Medicine's autonomy and authority to regulate itself depends on its ability to ensure that current and future generations of physicians acquire, maintain, and apply the values, knowledge, skills, and judgment essential for quality patient care. To fulfill this obligation, medicine must ensure that the values and core commitments of the profession protect the integrity of professional education. It must strive to deliver scientifically objective and clinically relevant information to individuals across the learning continuum. To promote continued innovation and improvement in patient care, medicine must sustain ongoing, productive relationships with the pharmaceutical, biotechnology, and medical device companies. However, industry support of professional education has raised concerns that threaten the integrity of medicine's educational function.

Conclusions: Existing mechanisms to manage potential conflicts and influences are not sufficient to address these concerns. Recognizing the profession-defining importance for medicine of achieving its educational goals, the Council recommends that:

- Individual physicians and institutions of medicine, such as medical schools, teaching hospitals, and professional organizations (including state and medical specialty societies) must not accept industry funding to support professional education activities. Exception should be made for technical training when new diagnostic or therapeutic devices and techniques are introduced. Once expertise in the use of previously new devices has developed within the professional community, continuing industry involvement in educating practitioners is no longer warranted.
- Medical schools and teaching hospitals are learning environments for future physicians at a critical, formative phase in their careers and have special responsibilities to create and foster learning and work environments that instill professional values, norms, and expectations. They must limit, to the greatest extent possible, industry marketing and promotional activities on their campuses. They have a further responsibility to educate trainees about how to interact with industry and their representatives, especially if and when trainees choose to engage industry in varying capacities after residency and fellowship training.
- The medical profession must work together to identify the most effective modes of instruction and evaluation for physician learners. It must then more efficiently develop and disseminate educational programming that serves the educational needs of all physicians. The profession must obtain more noncommercial funding of professional education activities.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-A-08

Subject: Industry Support of Professional Education in Medicine

Presented by: Mark A. Levine, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Raymond G. Christensen, MD, Chair)

1 The practice of medicine is inherently a moral activity, founded in a “covenant of trust” between
2 patient and physician.^{1,2,3} The status of medicine as a profession rests above all on its commitment
3 to fidelity and service in that relationship. As a profession, medicine must instill core professional
4 values and provide clinical training which ensures that current and future generations of physicians
5 are competent and caring. In return, society grants medicine considerable authority to set the
6 ethical and professional standards of practice and the autonomy to educate its practitioners.^{4,5}

7
8 Today, medicine is also engaged in multiple relationships with industry, defined as pharmaceutical,
9 biotechnology, and medical device companies, that are both engines of innovation and significant
10 sources of financial support for professional education. Commercial support now accounts for
11 approximately half of all income to nationally accredited providers of continuing medical
12 education (CME).⁶ The extent of industry support of undergraduate and graduate medical education
13 is less well documented, but industry spends considerable funds in support of the educational
14 mission of medical schools and teaching hospitals. For example, industry supports educational
15 travel grants for medical students and residents, provides free lunches at grand rounds and similar
16 events, and helps fund residency positions.

17
18 While industry and medicine share the overall goal of improving health, their interests and
19 obligations diverge in important ways. Commercial entities have a responsibility to their
20 shareholders and other vested stakeholders to thrive as businesses and maximize returns on
21 investment. Medicine has a responsibility to put the needs of patients first. As relationships
22 between medicine and industry continue to expand, there is growing concern about the impact of
23 industry funding on the integrity of professional education and its implications for public
24 confidence in medicine as a profession.

25
26 While the scope of medicine-industry relationships spans a wide spectrum from biomedical
27 research to clinical care, this Report focuses only on industry’s support of professional education in
28 medicine, and provides ethical guidance on how individual physicians and the profession as a
29 whole should address this critical issue.

30

* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

1 MEDICINE'S DUTY TO EDUCATE

2
3 *Publicly in his oath and privately in his encounter with the patient, the physician professes*
4 *two things—to be competent to help and to help with the patient's best interests in mind.*¹—
5 Edmund Pellegrino

6
7 The special moral character of the interaction between patient and physician arises from the need—
8 illness—that brings the patient into the relationship. Physicians are granted extraordinary privileges
9 to intervene in patients' lives, to impose harm in the service of healing, to gain access to sensitive
10 information, and to engage in intimate contact with patients that would otherwise be prohibited.
11 Educating current and future generations of physicians to fulfill the responsibilities that flow from
12 the patient-physician relationship is the foundation of medicine's status as a caring and competent
13 profession. Therefore, medicine's ethical duty to educate well is not one that can be delegated to
14 others.

15
16 To educate physicians for their roles as healers and members of a “learned” profession, medicine
17 must do two things: instill core professional values and impart clinical knowledge and skills.^{1-3,5,7,8}
18 The years of medical school and residency/fellowship training are a critical time in the
19 socialization of physicians as professionals. As trainees, medical students, residents, and fellows
20 solidify values and attitudes that will endure throughout their careers.^{2,9} Preserving the integrity of
21 professional education is paramount at this crucial, formative stage in professional development.
22 As lifelong learners, practicing physicians must maintain their clinical knowledge and skills
23 through continuing medical education and other professional development activities. Given the
24 wide array of diagnostic and therapeutic options available today, physicians and the patients who
25 rely on them must be confident that clinical decisions are informed by continuing medical
26 education activities that are pedagogically sound, scientifically valid, and clinically relevant.

27
28 To achieve these profession-defining goals, medicine must control the subject matter that is taught
29 and work to ensure the objectivity of educational content and of those who teach it. Yet there is
30 growing concern that medicine's increasing reliance on industry financial support of professional
31 education has undermined its status in society.¹⁰ As one recent commentary noted, “[w]hat is at
32 stake is nothing less than the privilege of autonomy in our interactions with patients, self-
33 regulation, public esteem, and a rewarding and well-compensated career.”¹¹

34
35 INDUSTRY FUNDING & THE INTEGRITY OF PROFESSIONAL EDUCATION

36
37 *Scope of industry support.* Over the past decade, medicine has come to rely significantly on
38 industry funding to support professional education across the learning continuum. Compared to
39 1998, commercial support of providers accredited by the Accreditation Council for Continuing
40 Medical Education (ACCME) increased by a factor of 300% to \$1.2 billion in 2006.⁶ According to
41 a 2006 national survey of department chairs at all U.S. medical schools and the 15 largest teaching
42 hospitals, 19% of respondents were paid by industry to participate as faculty or speakers in CME
43 activities; 14% were on company speakers' bureaus; and 16% accepted free or subsidized travel,
44 meals, lodging, and other personal expenses associated with attendance at meetings or conferences
45 related to their specific area of expertise.¹²

46
47 The extent of industry support for graduate and undergraduate medical education is less well
48 documented, but undoubtedly it is less than what is currently spent on continuing medical
49 education. In the previously cited 2006 survey, 25% of respondents reported that their departments
50 accepted financial support for residency or fellowship training; 38% accepted food and beverages;

1 and 22% accepted financial support for travel and meetings.¹¹ Of note, industry has also started
2 funding new residency positions in at least one specialty.^{13,14}
3

4 Estimates vary on industry's return on investment (ROI) from its various educational and
5 marketing activities.¹⁵ One study estimated that for every \$1.00 industry spent on CME programs
6 and other meetings yielded on average \$3.56 in increased revenue.¹⁶ This ROI is higher than what
7 has been estimated for pharmaceutical detail visits and direct-to-consumer advertising. Based on
8 these estimates, industry support for professional education is unlikely to fall; more likely it will
9 continue to grow for the foreseeable future unless steps are taken to intervene.

10
11 *Integrity of professional education.* Professional education in medicine is fundamentally grounded
12 in the ideal of scientific objectivity—in other words, education that is free of all bias. Given that
13 humans are thinking, feeling beings with strongly held beliefs, this ideal is never fully realized.
14 Nonetheless, articulating this ideal helps physicians gauge the soundness of their individual choices
15 and conduct, while challenging the profession to safeguard the integrity of how it educates its
16 current and future members.

17
18 Since it is not humanly possible to be free of bias, our perceptions and decisions are inevitably
19 subject to influence in ways we do not perceive.^{17,18} Thus it is important to understand what
20 informs and shapes individual and collective decisions. Professional judgment and conduct are
21 dictated by medicine's ethical imperative to put the welfare of patients first. Industry judgment and
22 conduct are driven by the economic imperative to produce products and services that earn a decent
23 return on investment for shareholders. Given the nature of these different imperatives, professional
24 and industry priorities cannot be assumed to be the same or even similar. Sometimes they *are*, but
25 whenever the priorities of medicine and industry are misaligned, and industry promotes its
26 priorities by supporting educational activities, the integrity of professional education is
27 undermined.

28
29 The most recent and best available evidence on the improper influence of industry-funded
30 educational activities on physician decision making are legal cases dealing with inappropriate
31 prescribing. In one prominent case brought by the U.S. Department of Justice, the makers of the
32 drug gabapentin (Neurontin™) were charged with using CME presentations as a major method of
33 promoting off-label uses of gabapentin.^{19,20} The company was charged with selecting speakers and
34 approving their presentation content specifically to ensure that physicians would be made aware of
35 off-label uses for this drug, despite laws that prohibit pharmaceutical companies from promoting
36 any drug for off-label use. The company ultimately settled the claims for \$430 million.

37
38 Another case brought against the maker of the drug oxycodone (OxyContin™) charged the
39 company with designing seminars, trainings and educational programs for physicians to serve the
40 same goals as the company's marketing strategies (e.g., detail visits to physician offices).²¹ The
41 company's efforts fraudulently promoted oxycodone as being less addictive, less subject to abuse,
42 and less likely to cause withdrawal symptoms than other pain medications. The claims were settled
43 for \$634 million.

44
45 Additional evidence on the relationship between industry-funded educational activities and
46 inappropriate prescribing is less recent and have small sample sizes. One study worth noting, in
47 part because its research design was quasi-experimental, evaluated whether industry-funded CME
48 led to increased prescribing of the company drug versus non-company drugs in the same
49 therapeutic class. Results revealed that the company drug was prescribed more often by physicians
50 after attending the company-supported CME event as compared to other drugs in the same class.²²

1 Another study examined physicians' prescribing patterns of two drugs before and after they
2 attended symposia sponsored by the manufacturers. Findings revealed that participants' usage of
3 both drugs increased significantly following the symposia and this differed significantly from
4 national prescribing patterns of the same drugs for the same time period in comparable clinical
5 settings.²³

6
7 In light of the inherent tension between professional and industry priorities and available evidence,
8 current efforts to ensure the independence of professional education are primarily aimed at
9 improving transparency through financial disclosures; and at mitigating influence through
10 mechanisms that insulate the recipient from direct control by the industry funder.

11 12 DISCLOSURE AND MITIGATION

13
14 *Limitations of disclosure.* Disclosing potential conflicts is often seen as an appropriate way to
15 manage them, but disclosure does nothing to eliminate the potential conflict.²⁴ Rather, disclosure
16 unfairly places the burden of managing the conflict on those to whom the disclosure is made,
17 charging them with determining how skeptical to be about the objectivity of the individual with the
18 potential conflict.²⁵ It is not reasonable to expect physician learners who are attending an
19 educational event to acquire new knowledge to be in a position to fully discern what "information"
20 provided by the presenter is objective or biased.

21
22 In addition, disclosure can have unintended consequences. First, the presenter, confident that the
23 conflict has been managed by his or her disclosure, may feel less of a need to strive for objectivity
24 – encouraging self-interested behavior on the part of the individual making the disclosure. Second,
25 for the learner, disclosure can convey the impression that the presenter is especially honest, and
26 therefore one need not be as skeptical about what is being presented. In other words, disclosure can
27 create a false sense of security about the objectivity of the educational content.²⁶

28
29 *Limitations of mitigation.* ACCME Standards for Commercial Support are designed to "ensure the
30 independence of CME activities" by establishing mechanisms that prohibit commercial funders
31 from having control over educational objectives, content, and methods, as well as selection of
32 faculty.²⁶ The standards also require accredited providers to take steps to resolve any conflicts of
33 interest between funders and individuals who have control over educational content *before* the
34 educational activity takes place.

35
36 Such mitigation measures are intended to insulate the educational responsibilities of accredited
37 providers from the marketing influence of industry funders. However, there is evidence that these
38 efforts are not sufficient to guarantee professional autonomy in the identification of topics,
39 selection of speakers, and development of educational content. Companies make educational grants
40 consistent with their overall business strategies and therapeutic areas of interest,^{27,18} shifting
41 education toward benefiting funders and away from patient interests.²⁸ Commercially supported
42 CME programs tend to address a narrower range of topics,^{29,18} focus more on drug therapies,²⁷ and
43 give more favorable treatment to company products³⁰ than do programs that are not commercially
44 funded.

45
46 In one national survey, a large number of department chairs believed that restricted financial
47 support from industry is more likely than unrestricted funding to compromise the ability of
48 academic faculty to provide independent, unbiased education.¹⁰ According to the survey, nearly
49 60% of respondents believed that restricted funds of greater than \$100,000 would have a negative
50 impact on the validity and objectivity of professional education; while almost 40% felt that way
51 about unrestricted funds, which are generally considered to confer the greatest degree of

1 professional autonomy in the development of educational programming. This study reveals the
2 degree to which many physicians are aware and acknowledge the influence of industry on the
3 objectivity of professional education.

4
5 But influence also operates below the level of awareness. Regardless of whether it is possible to
6 clearly differentiate between industry-supported “education” and “marketing,” both activities
7 ultimately aim to influence physician behavior. As opposed to industry-supported professional
8 education, successful marketing and promotional practices rely heavily on the ability of industry
9 representatives to establish and build personal rapport with physicians.³¹ This is routinely achieved
10 through the offering of gifts that often elicit the desire to reciprocate whether one is aware of it or
11 not.

12
13 We must stress that concern about industry influence in professional education is often about subtle
14 bias, not conscious corruption or wrongdoing. Influence is not the result of gullibility or lapse of
15 judgment on the part of physicians, but the inevitable result of how people respond to overtures of
16 perceived benevolence. Financial compensation, gifts, favors, or other benevolent gestures
17 introduce unconscious bias; they distort recipients’ decision-making by leading them to emphasize
18 data that support givers’ personal views or interests without recipients realizing that they are doing
19 so.¹⁵

20
21 Psychosocial and neurobiological studies indicate that our response to reciprocate what we
22 perceive as a benevolent gesture takes place below the level of conscious intention and independent
23 of the magnitude of the perceived benefit.^{15,16} Recall bias may also unintentionally affect
24 physicians’ behavior, for example, by unconsciously encouraging them to prescribe a drug that
25 comes first to mind for a condition when they have recently been exposed to detailing, ads, or other
26 promotions.³² Thus while physicians rightly pride themselves on their scientific training and
27 dedication to objectivity, the human reality is that critical reasoning ability by itself does not
28 guarantee that an individual can predict how interactions with industry affect his or her decision-
29 making.

30
31 Finally, with the exception of Food and Drug Administration regulations governing promotion of
32 drugs and medical devices, guidelines addressing relationships between industry and physicians or
33 medical organizations are voluntary.²⁰ At present there are no mechanisms for proactive oversight
34 or real-time monitoring adherence to existing ACCME standards for commercial support. Further,
35 accredited CME providers themselves have indicated that complying with guidelines is becoming
36 increasingly burdensome.³³

37 38 AN EDUCATIONAL IDEAL

39
40 In the history of American medical education, there have been critical moments when the
41 profession has made great strides in meeting its goals to educate and train its members to be caring
42 and competent. Next year marks the 100th anniversary of the publication of the Flexner Report,
43 which transformed how physicians were educated. These “Flexnerian” changes did not occur
44 overnight, but they ultimately established new norms and standards for how we educate and train
45 future generations of physicians.

46
47 The current system of professional education in medicine, with industry providing a significant
48 proportion of overall funding, is undermining those gains and the goals of professional education.
49 We are not convinced that attempting to manage industry influence in professional education is a
50 prudent use of resources. Rather, avoiding the influence altogether is essential to ensuring the
51 integrity of professional education. Avoiding influence-creating situations altogether is effective,

1 simple, and does not place the burden of sustaining objectivity entirely on individual physicians.
2 For example, some specialty societies from their inception have accepted virtually no industry
3 support for their educational activities. Similarly, some major medical centers have decided to
4 accept no industry support for continuing medical education,³⁵ as have some state physicians'
5 organizations.³⁴

6
7 In medical schools and teaching hospitals, industry gifts and other marketing activities are so
8 prevalent that it is increasingly difficult to separate these promotional influences from the
9 educational mission of these institutions. At this critical formative stage in their professional
10 development, medical students and resident physicians are exposed to modeling of behavior by
11 their teachers that is often at odds with the core commitments of physicians as professionals.⁹ As a
12 result, several medical schools and teaching hospitals have chosen to forgo gifts and meals from
13 pharmaceutical, biotechnology, and medical device companies.^{35,36} At the same time, these
14 institutions realize that medical students and resident physicians need to know how to interact with
15 industry and their representatives after they graduate. For example, such education and training
16 may include seminars or other didactic sessions that teach physicians to recognize possible bias in
17 industry-authored materials, and tools for self-study that enhance critical listening and questioning
18 skills. In addition, a number of academic medical centers have moved to significantly curtail and in
19 some cases eliminate outright, industry access to trainees and faculty.^{37,38}

20
21 Finally, studies of patients' attitudes reveal that they tend to disapprove of industry gifts to
22 physicians, including items that they believe might have some value for patients, such as free drug
23 samples.^{39,40} There is also evidence that patients find gifts less appropriate, and more influential,
24 than do their physicians.⁴¹ To our knowledge, no studies have specifically assessed patients'
25 perceptions of industry support for professional education, but surveys over the last decade
26 consistently show that pharmaceutical companies are among the industries the public thinks should
27 be regulated more stringently.⁴² While public perception should not dictate the debate about the
28 role that industry should have in professional education, it is important that medicine as a self-
29 regulating profession respond to these public concerns, lest they undermine patients' trust in
30 physicians.

31 32 REALIZING THE IDEAL

33
34 Divesting the medical profession of industry support for professional education raises two critical
35 questions: what is the best way to educate physicians, and how will it be financed?

36
37 To answer the first question, we must systematically examine how physicians learn and then
38 develop and test modes of instruction and evaluation that effectively impart essential knowledge
39 and skills that when applied, will positively impact the quality of care that physicians provide.
40 Many organizations have advocated for some variation of a "professional education research
41 institute" that will create the evidence base that will contribute to positive changes in how
42 physicians learn to care for patients.^{43,44} Doing so will require resources, but it is necessary in order
43 to establish that professional education is based on the most effective methods of teaching and
44 learning.

45
46 Even as we move to advance the science of adult learning in medicine, we acknowledge that
47 industry involvement in professional education is required when new diagnostic or therapeutic
48 devices and techniques are introduced in medicine. Industry and their representatives are
49 sometimes the only "teachers" qualified to train physicians on how to use devices safely and
50 effectively, especially in the early stages of a device's introduction. It is appropriate and necessary
51 that industry representatives, or physician-innovators whose work led to the innovation, have an

1 educational role in these learning situations. However, once expertise has developed within the
2 professional community, continuing industry involvement in educating practitioners is no longer
3 warranted. Given the dissemination and adoption patterns of new technological innovations in
4 medicine, it is not possible to determine with absolute certainty when the transition from early
5 adoption to mature clinical practice has occurred. One potential indicator that this educational
6 transition has taken place is when physicians have access to competing devices in the same
7 diagnostic or therapeutic category. Technical assistance or support that industry representatives
8 may provide physicians in the context of patient care (e.g., helping a surgeon in the operating room
9 select the appropriately sized prosthesis component) is considered professional education and is not
10 ethically inappropriate.⁴⁵

11
12 To address the second question, we recognize that adopting a policy banning industry support of
13 professional education poses significant resource challenges to some organizations in the
14 immediate term. For many institutions, disentangling medical education from industry support will
15 call for major changes in organizational culture and cultivation of alternative funding streams. A
16 learning environment free of industry influence and that upholds the integrity of professional
17 education cannot be created overnight; such a transformation will demand ongoing, dedicated
18 leadership and committed action at all levels of the profession over the long term.

19
20 It should be noted that industry support does not necessarily lead to efficient educational
21 programming. More than half of all commercial support goes to medical education and
22 communication companies, which rely almost exclusively on industry funding but only provide 8%
23 of the total hours of CME instruction. In comparison, medical schools receive 21% of total
24 commercial support, but provide almost half (46.5%) of the total hours of CME instruction.⁶ These
25 figures suggest that a significant portion of industry funding does not necessarily result in the
26 development of actual educational programming, regardless of the impact of industry funding on
27 the objectivity of educational content.

28
29 The importance of spending every educational dollar as efficiently as possible is especially
30 pertinent for physicians who practice outside large, urban academic settings—for example, those in
31 community hospitals and rural clinics. Smaller and rural institutions in medicine will likely require
32 more time to transition to a point where they no longer rely on industry support for educational
33 activities. Large academic medical centers that have already moved to eliminate industry support of
34 their educational mission must be prepared to help during this transition by developing and
35 disseminating relevant specialty-specific educational programming to colleagues in these practice
36 settings. Medicine might consider following the example of non-medical educational institutions
37 that have made their entire curriculum available free over the Internet.⁴⁶

38
39 Many have also argued that ending industry support will decrease CME availability, independent
40 of how efficiently and effectively the resources are spent in producing CME.^{47,48} If that is the case,
41 physicians must also advocate for more noncommercial sources of funding for educational
42 activities—the education of physicians is a public good whose burden should not be shared by the
43 profession alone.

44
45 Finally, challenges, seen and unforeseen, will undoubtedly arise as the medical profession realizes
46 this educational ideal, but we are confident that none of them are insurmountable. More than 160
47 years ago, the American Medical Association came into being in response to threats that stood to
48 undermine the integrity of professional education of physicians. Our young organization was then
49 instrumental in promulgating standards for rigorous, systematic, scientifically sound medical
50 education. It was a driving force behind the Flexner Report that transformed the system of

1 American medical education almost a century ago. It must and will live up to that legacy of
2 leadership to address any risks to the integrity of professional education today.

3
4 RECOMMENDATION

5
6 The Council on Ethical and Judicial Affairs recommends that the following be adopted and that the
7 remainder of this report be filed:

8
9 Medicine's autonomy and authority to regulate itself depends on its ability to ensure that
10 current and future generations of physicians acquire, maintain, and apply the values,
11 knowledge, skills, and judgment essential for quality patient care. To fulfill this obligation,
12 medicine must ensure that the values and core commitments of the profession protect the
13 integrity of professional education. It must strive to deliver scientifically objective and
14 clinically relevant information to individuals across the learning continuum—from medical
15 school, into residency and fellowship training, and throughout continuing medical education.

16
17 To promote continued innovation and improvement in patient care, medicine must sustain
18 ongoing, productive relationships with the pharmaceutical, biotechnology, and medical device
19 companies. However, industry support of professional education has raised concerns that
20 threaten the integrity of medicine's educational function. Existing mechanisms to manage
21 potential conflicts and influences are not sufficient to address these concerns.

22
23 Given medicine's current reliance on industry funding of professional education, implementing
24 the following recommendations will take time. Yet we must recognize the profession-defining
25 importance of ultimately achieving these goals. To that end:

26
27 (1) Individual physicians and institutions of medicine, such as medical schools, teaching
28 hospitals, and professional organizations (including state and medical specialty societies)
29 must not accept industry funding to support professional education activities. Examples of
30 such activities include, but are not limited to, industry funding for:

- 31
32 (a) residency positions and clinical fellowships;
33
34 (b) didactic educational programs, such as live or web-based continuing medical education
35 activities;
36
37 (c) physician speakers' bureaus; and
38
39 (d) travel, lodging, and amenities for participants of clinically relevant educational
40 programming.

41
42 (2) One exception to no industry support of professional education is when new diagnostic or
43 therapeutic devices and techniques are introduced. Given the requirement for technical
44 training on how to use new devices, industry representatives may have to play an
45 educational role because they could be the only available teachers. But once expertise in the
46 use of previously new devices has developed within the professional community,
47 continuing industry involvement in educating practitioners is no longer warranted.
48 Technical assistance or support that industry representatives may provide physicians in the
49 context of patient care (e.g., helping a surgeon in the operating room select the
50 appropriately sized prosthesis components) is not considered professional education and is
51 not ethically inappropriate.

1 (3) Medical schools and teaching hospitals are learning environments for future physicians at
2 a critical, formative phase in their careers. These institutions have special responsibilities
3 to create and foster learning and work environments that instill professional values, norms,
4 and expectations. They must limit, to the greatest extent possible, industry marketing and
5 promotional activities on their campuses. Examples of such activities include, but are not
6 limited to:

- 7
8 (a) free food and other industry gifts for trainees and faculty, and
9
10 (b) detailing visits by industry representatives.

11
12 Medical schools and teaching hospitals have a further responsibility to educate trainees
13 about how to interact with industry and their representatives, especially if and when
14 trainees choose to engage industry in varying capacities after residency and fellowship
15 training.

16
17 (4) The medical profession must work together to:

- 18
19 (a) identify the most effective modes of instruction and evaluation for physician learners,
20 then;
21
22 (b) more efficiently develop and disseminate educational programming that serves the
23 educational needs of all physicians, especially for those who have difficulty accessing
24 continuing medical education (such as those who practice in rural areas); and
25
26 (c) obtain more noncommercial funding of professional education activities.

27
28 (New HOD/CEJA Policy)

Fiscal Note: Staff cost estimated at less than \$500 to implement.

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