Rethinking continuing medical education

Drug company funding of continuing medical education may affect doctors' independence. **Alfredo Pisacane** argues that it can and should be stopped

Continuing medical education has become so heavily dependent on support from drug and medical device companies that the ethical underpinnings and the reputation of the medical profession may be compromised. In industrialised countries, drug companies support more than half of continuing medical education activities, and it has been shown that such support can distort the topic selection, embellish the positive elements as well as play down the adverse effects of some interventions, and influence doctors' prescribing habits.[1-4]

To reduce the risk of conflict of interest in continuing medical education, it has been proposed that sponsors should not have any influence over the choice of speakers and scientific contents; moreover, providers and speakers of educational events should provide a full disclosure of the support received. Such disclosure, however, does not protect against the risks of an invisible influence of drug companies on providers, speakers, and participants.[5]

Continuing medical education is compulsory in Italy, and the Ministry of Health has recommended that local health authorities spend 1% of their total budget on educational activities. Nevertheless, most authorities spend much less than the recommended amount and up to 60% of the money comes from drug companies.

Because commercial support represents a substantial part of the resources available for educational activities, it may seem essential. However, for the past five years I have organised educational events at an Italian university hospital with no financial support from drug companies. Here, I present seven proposals for limiting the commercial support to continuing medical education.

Concentrate on small groups

One of the reasons for the high costs of continuing medical education is that most is based on conferences, meetings, and workshops. These are expensive and do not have any proved effect on doctors' behaviour or outcomes of health care. My first proposal is to move away from conferences and instead promote educational events relying on accurate needs assessment, linked to practice, and organised in small groups. Activities such as clinical audit, outreach visits, feedback, and reminders have more effect on doctors' behaviour and healthcare outcomes than traditional lectures.[6-8] Such events could be held inside the health institutions and, as a consequence, expenses for trips, meals, and entertainment would be limited.[9]

In the past five years, over 250 educational events were organised in my hospital; only eight were workshops with more than 100 participants, the others were mainly team based, small group and interdisciplinary meetings aimed at improving clinical practice and quality of care. The cost of such events was low and no extra financial support was needed above the resources that the hospital had provided for continuing education activities.

Doctors were more reluctant than other professionals to accept the shift from traditional lectures to small group work. Continuing medical education records show that over 90% of nurses and other professionals participated in educational events organised by the hospital, compared with less than 20% of doctors, who mostly attended traditional, usually industry supported, conferences held outside the hospital and targeted only at physicians. The Ministry of Health, however, has recently indicated that at least half of continuing medical education activities should be linked to practice, team based, and organised with adequate adult learning techniques.[10]

The feasibility of a small group approach to continuing medical education has been investigated in several countries. Improvements in clinical practice and healthcare outcomes have been reported when learning was through audit and feedback, outreach visits, and reminders.[11-14] No data are available on the effect of conferences and lectures on doctors' behaviour and health outcomes.

Agree objectives for educational activities

National or local health authorities, in agreement with professional organisations and scientific societies, should identify a list of essential educational objectives for continuing medical education. Such objectives, based on adequate needs assessment, should be directed at improving practice and outcomes of health care. Educational objectives should also be tailored to each category of health professional. Only those educational events whose objectives are on the essential list will be able to award development credits.

The Italian Ministry of Health has identified a list of educational objectives for continuing medical education.[10] Unfortunately, these objectives are too vague and do not specify what health professionals should learn or be able to do at the end of an

educational event. As a consequence, clear indicators for evaluating the educational events are not available. I have identified specific objectives for each educational event I have organised, and in most cases it has been possible to evaluate the effect of training activities on competencies and, sometimes, on clinical practice of participants.[15]

Evaluate providers

Providers of education (medical schools, hospitals, professional organisations, scientific societies, and publishing and education companies) should be carefully evaluated. They should be able to dispense credits only if they organise educational events targeting the agreed essential objectives, the education focuses on small interdisciplinary groups and uses appropriate adult teaching methods,[16] and they are able to systematically evaluate the effect of the educational activities on the behaviour of participants and on quality of care.

"Activities such as clinical audit, outreach visits, feedback, and reminders have more effect on doctors' behaviour and healthcare outcomes than traditional lectures"

My experience shows that meeting these criteria is feasible. At present, about 10 doctors (out of over 700 in my hospital) and 40 nurses and other professionals (over 1600) have got experience in organising educational events based on team work and a small group approach and, when teaching a course, are able to identify specific objectives and indicators for the evaluation.[15]

Health institutions should commit resources

Each health institution should dedicate a percentage of its budget for continuing medical education activities. The budget will cover only the list of essential educational objectives identified by health authorities and will be mainly used for in-service training and small group activities.

Make use of new technology

National health authorities should create a central office for e-learning and should identify the types of educational activities that work with this method. E-learning courses incorporating the essential educational objectives can receive credits and be freely available for all health professionals. In Italy, the Ministry of Health and the National Drug Agency have launched a free online resource,[17] based on *Clinical Evidence*, and have provided continuing education courses for over 26 000 doctors and 56 000 nurses up to the end of 2007. In the United Kingdom, interesting models of e-learning, such as the doctors.net.uk and BMJ Learning, have shown that it is possible to use the web for good quality continuing professional development.[18] Moreover, videoconferences can be an affordable way of communicating with colleagues.

Create a central fund

Instead of drug companies supporting specific events or individuals they could be asked to contribute to a central repository of funds or a blind trust for an institution or group of institutions.[19] A scientific committee would choose the educational events to support, and the events would include all health professionals, not just doctors. Organisers, speakers, providers, and health professionals would not have any contact with private companies and it could be ensured that the events met the agreed essential educational objectives and used substantiated learning techniques. Although drug companies would not be able to select which activities to support, some of them may agree to support a blind trust because it gives them the opportunity to become leaders, rather than targets, of regulatory initiatives to enforce stronger ethical standards regarding their relationships with doctors.[20]

Ask doctors to pay

The final proposal is that doctors should pay a modest fee for their continuing education and that such expenses should be taken into account in their tax payments, as happens with professionals in other fields. The "No free lunch" campaign[21] and a large debate in the literature[4 19] have shown that many doctors are prepared to pay towards their continuing education. I recently organised a 12 hour course for 200 Italian family paediatricians, costing €50 (£40; $79); everybody agreed to pay, and no commercial support was needed.

In conclusion, if a more evidence based approach to continuing medical education is achieved, not only would this result in cheaper solutions but financial support from the drug industry would no longer be required. This is a first good reason for a change. But there is another reason, which is probably even more important. Our patients believe in our competence and honesty. What would happen if they suspected that our continuing education was not only directed at improving our clinical competence and their health but also at promoting commercial interests? The rofecoxib affair has shown that a company can sponsor "countless symposiums in an effort to debunk the concern about the adverse effects of a drug."[22] People should be confident that marketing and markets will not be allowed to undermine doctors' commitment to their patients' best interests or to scientific integrity.

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