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HEART OF THE MATTER

CME and Pharma

n the beginning, continuing medical education was the province of medical schools, supported in part by federal funds.

In the 1980s the pharmaceutical in-

dustry, later joined by the device industry, developed a series of blockbuster drugs and devices that had the potential to benefit large numbers of patients with cardiovascular diseases. In order to educate physicians about these new advances, CME programs appeared to be a natural vehicle. The federal government had long given up on its support of out-

reach programs, and academic medical centers saw industry support as a way to expand both postgraduate and house staff educational programs.

The pharmaceutical and device industries saw CME as a method for marketing their products to physicians in the hospital setting, while providing an educational service to the medical profession. There was a clear need to educate physicians in the use of new and effective drugs that were developed to treat hypertension, angina, and postmyocardial infarction patients. Drug and device manufacturers could use academics and investigators who had participated in clinical trials to carry the message of the trials to the physician. This proved to be a very effective way of translating the results of clinical trials to the bedside, and

it led eventually to evidence-based medicine and clinical guidelines.

By wrapping their product information inside a bona fide, disease-centered scientific program, drug and device manufacturers could advance both the principles of good medicine and the use of their products. Using academic medical centers, industry could achieve legitimacy, and by carefully

selecting members of "speakers' bureaus," it could make sure that doctors, both familiar and sympathetic to its products, articulated its message.

The pharmaceutical and device industries now support almost the entire spectrum of CME, from house staff lunches to the conventions of our national medical organizations. Without their support, postgraduate medical education would collapse. Medical educators have not been naive to the mixed motives of industry. In the last decade, industry has established a variety of guidelines by which medical education programs are monitored and conducted. Many of the excesses have been largely corrected.

To some, the intimacy of industry with medical education is still uncomfortable, and to others it is considered unethical. Proposals in editorials (JAMA 2006;295:429) and reported in this newspaper have suggested several changes in the relationship of industry to CME. These include the nonparticipation of academic faculty in speakers' bureaus and the construction of educational pools funded by industry and administered by academic medical centers in which industry input would be barred.

It remains to be seen how far academia and industry will be willing to participate in these changes. There is little question of the tremendous need for CME in our rapidly changing medical world. There is clearly a lack of funds from any other source. It is also apparent that industry depends on an educated medical profession to sell its products. Everyone can benefit by creating an educational environment focused on science and free of marketing bias.

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