Adapting to Decreased Industry Support of CME: Lifelong Education in an “Industry-Lite” World

Joel Yager, M.D.
Joel J. Silverman, M.D.
Mark Hyman Rapaport, M.D.

The continuing medical education (CME) enterprise in academic medicine is changing rapidly because of a number of important factors: the change in CME doctrine promulgated by the Accreditation Council for Continuing Medical Education (ACCME) (1), the refinement of the criteria for maintenance of certification (MOC) by the American Board of Medical Specialties (ABMS) (2), and alterations in patterns of commercial sponsorship for educational events by pharmaceutical and device industries. This article focuses on how alterations in the patterns of commercial support for educational events at academic medical centers and universities are changing the CME opportunities for faculty and trainees associated with academic departments of psychiatry.

Historically, commercial funding has subsidized and supported considerable CME activity in academic medical centers. A 2006 survey (3) indicated that 49% of CME course costs at academic centers were funded by industry. Commercial sponsorship of CME has taken several forms. Commercial companies, either directly or through their educational intermediaries, have sponsored Grand Rounds speakers in academic departments, either as members of speakers’ bureaus or via individual grants. These companies have also helped underwrite the costs of CME conferences sponsored by academic departments through their universities. Also, commercial companies have sponsored journal clubs and dinner meetings with speakers for practitioners in the community, often at reasonably attractive restaurants, as well as travel funds for faculty, residents, and fellows to attend national and international meetings.

Through “medical education and communication companies,” which have frequently partnered with academic departments of psychiatry, industry has sponsored educational activities with online options, teleconferences, and videoconferences and the development and production of CME events in conjunction with professional-association meetings. Traditionally, these offerings feature top names and excellent media production, and they draw large audiences. Thus, increased levels of commercial support have helped proliferate different approaches for physicians to receive free CME. At times, these presentations may become vehicles for commercial entities to “educate” practitioners in a manner that is conducive to acceptance of a product or a specific class of agents for treatment interventions. In 2008, pharmaceutical and medical-device companies funded half of the $3 billion CME industry, and much of this money was directed to for-profit medical-communication companies that organize CME programs and symposia (4).

Well-warranted concerns about ethics issues and the educational implications of marketing biases and academic leaders’ industry ties (5), raised by public scrutiny, Congressional investigations, and leaders in the medical profession, have led pharmaceutical and device companies to revise their funding patterns and practices. The overall effect has been a severe curtailment of industry funding of CME activities. Academic departments and organizations that relied on commercial largess have been increasingly deprived of the funds previously available for CME activities. According to industry sources, many providers now
receive at least 30%–40% less funding from industry sources for CME than previously (6). Decreased industry spending on CME has been of substantial concern to the field of psychiatry and to organized medicine as a whole (7–9).

This commentary considers how academic departments have responded to these funding decrements. It is based on presentations and extended discussions at an October 2009 workshop jointly sponsored by the American Association of Chairs of Departments of Psychiatry (AACDP) and the Association for Academic Psychiatry (AAP). We describe innovative opportunities for providing CME and how the profession might best move forward with respect to both CME accreditation requirements and the development of forums for lifelong education that promote learning and better health outcomes.

**Workshop Structure**

The workshop began with three 10-minute presentations, during which the authors addressed historical developments and recent trends in industry sponsorship of CME, the perspectives of chairs of academic departments of psychiatry, and APA’s efforts to deal with current and future needs regarding CME. At the start, 4 x 6 index cards were distributed to the audience; participants were asked to write down ways in which funding changes had affected their CME programming and how their departments were contending with these changes: 26 cards, containing 61 comments and suggestions, were collected, representing approximately a two-thirds response rate from the audience (a list of representative participants appears in the Acknowledgment section). In the final hour of the workshop, the comments were read aloud and discussed.

The decrease in industry funding for CME has clearly forced academic departments to address three major issues:

---

**Decreased Funding Has Significantly Affected Management of Grand Rounds, Extended CME Events, and Other Educational and Social Functions in Academic Departments**

As a result of decreased support, many departments report that they engage fewer nationally-renowned, out-of-the-geographic-area speakers for Grand Rounds and CME conferences. Departments have less or no support for meals associated with Grand Rounds and other departmental functions and have less discretionary support for varied conference expenses. Many departments have entirely eliminated industry funding for any educational retreats. This has significantly affected many different aspects of departments, including residents’ conferences, holiday parties, and graduation ceremonies.

**CME Activities Are Not the Same as CME Category I Credit**

The costs of providing Category I CME credit has led some academic departments to reduce or abandon providing Category I credits for attendees at Grand Rounds and/or other CME conferences.

Changed circumstances have required faculties to rethink the functions of CME, adaptively address these functions with fewer resources, and creatively attempt to increase resources for CME. Participants described and envisioned a number of adjustments, modifications, and “out-of-the-box” solutions to ensure that high quality and meaningful CME activities can continue.

From the workshop discussion, we are able to describe simply what is being attempted in various programs. However, except for anecdotes, evidence-based data are lacking concerning how successful or unsuccessful these various ventures have been for participant satisfaction or educational outcomes.

**Adaptive Modifications and Solutions to Academic CME-Related Issues**

**Grand Rounds** Overall, participants recognized that the institution and rituals of Grand Rounds serve several important functions. Historically, Grand Rounds were occasions where the most clinically interesting and challenging cases were presented to the highest tier of experts for discussion. In subsequent decades, they evolved into departmental conferences where visiting notables presented cutting-edge research or reviews of emerging areas of interest. They provided attendees with opportunities to see and hear well-known authorities in the field. Because departments were easily able to increase the “star power” of these presentations by using industry-funded speakers and offer catered meals (also provided by industry), many Grand Rounds were scheduled at the noon-hour. For full-time faculty, residents, medical students, and volunteer faculty from the community, these sessions offered information, the chance to meet with professional leaders, Category I CME, opportunities to socialize with colleagues, and free food. Modifications reflect shifts in funding, programming, CME Category I credits for Grand Rounds, and food. Overall, workshop participants have described an increasing need for “managed expectations” in these areas.