

REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-11)
Financial Relationships with Industry in Continuing Medical Education
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

Relationships between medicine and industry—such as pharmaceutical, biotechnology, and medical device companies—have driven innovation in patient care, contributed to the economic well-being of the community, and provided significant resources (financial and otherwise) for professional education, to the ultimate benefit of patients and the public. The interests and obligations of medicine and industry diverge in important ways, however. An increasingly urgent challenge for both partners is to devise ways to preserve strong, productive collaborations for the benefit of patients and the public at the same time they each take clear, effective action to avoid relationships that could undermine public trust.

This report examines financial relationships between medicine and industry in the specific context of continuing medical education. It summarizes the ethical foundations of medicine's obligation to ensure that physicians acquire and maintain the knowledge, skills, and values that are central to the healing profession. The report analyzes the ethical challenges that can be posed when physicians who organize, teach in, or serve other roles in continuing medical education have financial relationships with companies that have a direct interest in physicians' recommendations and illustrates strategies for mitigating the potential of such financial relationships to influence professional education in undesired ways. It identifies core ethical principles of transparency, independence, and accountability and provides practical ethical guidance to maintain the independence and integrity of continuing professional education and promote public trust.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-A-11

Subject: Financial Relationships with Industry in Continuing Medical Education

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Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Patricia L. Austin, MD, Chair)

1 Relationships between medicine and industry—such as pharmaceutical, biotechnology, and
2 medical device companies—have driven innovation in patient care, contributed to the economic
3 well-being of the community, and provided significant resources (financial and otherwise) for
4 professional education, to the ultimate benefit of patients and the public.[1,2] The interests and
5 obligations of medicine and industry diverge in important ways, however. An increasingly urgent
6 challenge for both partners is to devise ways to preserve strong, productive collaborations for the
7 benefit of patients and the public at the same time they each take clear, effective action to avoid
8 relationships that could undermine public trust.

9
10 As relationships between medicine and industry have evolved, major national organizations, such
11 as the Institute of Medicine (IOM)[3] and the Association of American Medical Colleges
12 (AAMC)[4,5,6] have explored the challenges that these relationships can pose in research, clinical
13 care, education, and beyond. Key stakeholders, including (among others) the Accreditation
14 Council for Continuing Medical Education (ACCME),[7] the Council of Medical Specialty
15 Societies (CMSS),[8] and the Pharmaceutical Research and Manufacturers Association
16 (PhRMA)[9] have developed guidance to help their constituents sustain appropriate, productive,
17 and professional interactions.

18
19 The American Medical Association was founded on the vision that as medical professionals,
20 physicians should represent the highest standards of competence, integrity, and professionalism.
21 This report carries that vision forward. It examines ethical aspects of medicine-industry
22 relationships in continuing medical education (CME), explores ethical challenges that can be posed
23 by financial relationships from the perspective of physicians, and provides guidance for members
24 of the medical profession who attend or who organize, teach in, or serve other roles in CME.

25
26 The Council on Ethical and Judicial Affairs recognizes that pharmaceutical, biotechnology, and
27 medical device companies are not the only entities with which financial relationships can raise
28 concerns. CEJA likewise recognizes that CME is not the only domain of potential concern.
29 However, narrowing our focus to CME allows us to explore the complex considerations at stake in

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1 a manageable context and to provide practical ethical guidance on issues that increasingly
2 challenge physicians as professionals.

3
4 LIFELONG LEARNING & MEDICINE'S DUTY TO EDUCATE

5
6 *Publicly in his oath and privately in his encounter with the patient, the physician professes*
7 *two things—to be competent to help and to help with the patient's best interests in mind.*

8 — Edmund Pellegrino[10]
9

10 The practice of medicine is inherently a moral activity, founded in a “covenant of trust” between
11 patient and physician.[10,11,12] The respect and autonomy that medicine enjoys rest on the
12 profession’s commitment to fidelity and service in the patient-physician relationship. To sustain
13 that commitment, medicine must ensure that physicians acquire and maintain the knowledge, skills,
14 and values that are central to the healing profession. In return, society grants medicine
15 considerable authority to set the ethical and professional standards of practice and the autonomy to
16 educate practitioners.[13,14]
17

18 The special moral character of the interaction between patient and physician arises from the need—
19 illness or the prevention of illness—that brings the patient into the relationship. Physicians are
20 granted extraordinary privileges to intervene in patients’ lives. Patients entrust to physicians the
21 care of their bodies and the protection of sensitive information revealed in confidence for the
22 purpose of seeking healing. Educating current and future generations of physicians to fulfill the
23 responsibilities that flow from the patient-physician relationship is the foundation of medicine’s
24 status as a caring and competent profession. Thus medicine’s ethical duty to educate cannot be
25 delegated to others.
26

27 Individual physicians have an ethical obligation to dedicate themselves to “continue to study,
28 apply, and advance scientific knowledge” and to “maintain a commitment to medical
29 education.”[15] As professionals, practicing physicians are expected to commit themselves to
30 lifelong learning and to maintain their clinical knowledge and skills through CME and other
31 professional development activities.[16] That commitment is reflected not only in ethical
32 expectations and standards, but also in requirements for licensure and specialty certification, as
33 well as hospital credentialing.
34

35 Physicians and the patients who rely on them must be confident that treatment recommendations
36 and clinical decisions are well informed and reflect up-to-date knowledge and practice. CME
37 activities that are pedagogically sound, scientifically grounded, and clinically relevant are essential
38 to ensure that physicians can provide the high quality of care their patients deserve. To achieve
39 these goals, medicine has an ethical obligation to ensure that the profession independently sets the
40 agenda and defines the goals of physician education; controls what subject matter is taught;
41 determines physicians’ educational needs; and takes steps to ensure the independence of
42 educational content and of those who teach it. The importance of doing so may extend well
43 beyond continuing education—as one commentary noted, “[w]hat is at stake is nothing less than
44 the privilege of autonomy in our interactions with patients, self-regulation, public esteem, and a
45 rewarding and well-compensated career.”[17]

1 CONTINUING MEDICAL EDUCATION

2
3 Continuing medical education today takes place in an environment that includes “promotional”
4 activities, “certified CME,” and noncertified CME. Promotional activities lie outside the scope of
5 the present analysis and recommendations. As defined by the Food and Drug Administration
6 (FDA), these are activities developed by or on behalf of a commercial entity and under the
7 substantive influence of that entity to provide information on the therapeutic use of a product or
8 service. They are governed by the labeling and advertising provisions of the Food, Drug, and
9 Cosmetic Act,[18,19] and may constitute protected commercial speech.

10
11 “Certified CME” refers to educational activities developed and implemented in compliance with
12 the certification requirements of the American Medical Association Physician Recognition Award
13 (PRA) CME Credit System or the accrediting policies of the American Academy of Family
14 Physicians or American Osteopathic Association.[20] Certified CME meets the requirements for
15 Category 1 credit under AMA’s PRA program, including compliance with Accreditation Council
16 for Continuing Medical Education (ACCME) standards and with relevant AMA ethics policy.[21]

17
18 Beyond these formal categories lie activities designed to inform and educate practicing physicians
19 that are neither promotion nor certified CME. These other activities may or may not be
20 commercially supported, may or may not voluntarily adhere to AMA policy or ACCME Standards
21 for Commercial SupportSM (even if they are not formally certified or offered by formally accredited
22 providers), and may or may not be recognized by licensing bodies or credentialing boards as
23 fulfilling CME requirements.

24
25 Physician involvement is critical in CME. Individually and collectively, physicians play key roles
26 in educating their peers, as teachers, content developers, organizers of CME, or in other capacities.

27
28 *Financial Relationships with Industry in CME*

29
30 In the context of continuing medical education, relationships with industry that may pose
31 challenges for the independence and objectivity of physician education include not only direct
32 industry support of CME activities, but also financial relationships between industry and individual
33 physicians involved in CME as faculty, content developers, or in other capacities.

34
35 Industry support for CME has declined in recent years, but commercial funding still accounts for
36 approximately 40 percent of overall CME-related revenue, ranging from less than one percent to
37 just over 60 percent across accredited CME providers.[22] A growing number of accredited
38 providers—20 percent as of July 2009—no longer accepts any commercial support at all.[23]

39
40 Industry support helps to meet the costs of CME activities in the face of uncertain funding from
41 other sources[24] and may help make CME more accessible, especially for physicians in resource-
42 poor communities.[25] Industry engagement and support can be especially helpful in ensuring
43 affordable CME when educational activities need high cost, sophisticated, rapidly evolving
44 technology or devices. Along with lower costs, industry support may encourage greater
45 participation than would otherwise be the case by providing amenities. As yet there is no peer-
46 reviewed evidence to support or to refute the effect of industry funding on accessibility of or
47 participation in CME activities.[26]

1 However, there is growing concern within and outside medicine that industry funding for CME
2 could have undesirable effects, including potentially biasing content toward funders' products and
3 influencing the overall range of topics covered.[27,28,29,30] Importantly, where patients' health
4 and public trust are concerned, the perception of bias, even if mistaken, can be as potentially
5 damaging as the existence of actual bias.

6
7 *Influence, Evidence & Ethics*

8
9 Whether or how financial relationships influence CME activities or the overall CME curriculum is
10 an important question. But answering this empirical question cannot resolve the core ethical
11 challenge, no matter what the evidence should prove to be. Physicians are entrusted with the
12 interests of patients. Where trust is central, the *appearance* of influence or bias can be as damaging
13 as actual influence. Empirical evidence alone is not enough to overcome public skepticism. Even
14 evidence that undesired consequences have not occurred cannot be expected by itself to restore
15 confidence when trust has been compromised.

16
17 The available data neither support nor disprove that financial relationships influence CME.
18 Standards have been established to address concerns about possible influence in CME, such as the
19 ACCME Standards for Commercial Support.SM The efficacy of those standards or other processes
20 to address the potential for industry influence on content or the overall range of CME topics is
21 difficult to determine. Several recent studies have suggested that the great majority of physicians
22 attending CME activities do not perceive bias in the content of those activities, based on their
23 responses to questions about bias on standard evaluations of CME activities.[31,32,33] As the
24 authors themselves note, these studies are subject to limitations, such as the "insensitivity of simple
25 'yes/no' questions to assess learners' perceptions of bias." [33, cf. 32, cp., 34]

26
27 Other research indicates that individual physicians, like everyone else, are subject to influence,
28 even if they are not aware of how industry support of a CME activity could affect their clinical
29 decisions.[35,36,37,38,39] Further, a recent review of the relevant literature found that although
30 there is clear evidence that CME influences physicians' prescribing practices, the question of what
31 effect changes in prescribing have on actual patient outcomes has not specifically been studied.[39]

32
33 To maintain productive relationships with industry that benefit patients and to sustain the trust on
34 which the patient-physician relationship and public confidence in the profession depend, medicine
35 must take steps to safeguard the independence and integrity of physician education.

36
37 ENSURING THE INDEPENDENCE & INTEGRITY OF CME

38
39 CEJA recognizes that competing interests are a fact of life for everyone, including but not limited
40 to physicians. For physicians, however, even very modest potential or perceived competing
41 interests can put trust at risk. As individuals and as a profession, physicians have a responsibility
42 to protect the quality of professional education and the reputation of medicine. While competing
43 interests cannot be eliminated entirely, prudent judgments can be made about how to minimize
44 potential influence and prevent or reduce undesired consequences.

1 *Minimizing the Opportunity for Influence*

2
3 Physicians should aspire to avoid the potential for influence or the chance that confidence in the
4 integrity and independence of their professional education could be diminished. Avoiding entirely
5 situations in which there is potential for influence has the virtue of ethical clarity and practical
6 simplicity. CME that is free of financial relationships with companies that have direct interests in
7 physicians' recommendations strongly underscores medicine's defining professional commitment
8 to independence and fidelity to patients. Avoiding such relationships also has the practical
9 advantage of eliminating the administrative and resource costs that must otherwise be devoted to
10 mitigating influence,[40] costs that may be particularly challenging for smaller CME providers.[25]

11
12 In their roles as CME providers, content developers, and faculty, physicians should strive to avoid
13 financial relationships with industry. The Institute of Medicine has called for development of a
14 new system of funding CME that is free of industry influence.[3] Medicine should cultivate
15 alternative sources of support, should design and conduct educational activities so as to reduce
16 costs, and should insist that content developers and faculty members not have problematic ties with
17 industry to ensure independent, unbiased, high quality educational programming that best meets
18 physicians' needs and is accessible and affordable for all practitioners.

19
20 Changing the terms of financial relationships likewise can help minimize the potential for
21 influence. For example, physicians who have decision-making authority in organizations that
22 provide CME could set an upper limit on how great a proportion of the organization's income
23 derives from industry support to ensure that the organization does not become overly reliant on
24 commercial funding. Asking physicians who teach in or develop content for a CME activity to
25 refrain from accepting compensation (honoraria, consulting fees, etc.) for a defined period before
26 and after the activity from a commercial supporter that has an interest in the educational subject
27 matter could similarly promote independence. Decisions to require that physicians involved in
28 CME as faculty members or in other roles change the terms of their relationships with industry
29 must, of course, be made fairly and consistently across individual cases.

30
31 That said, it is not always feasible, or necessarily desirable, for professional education to disengage
32 from industry completely. In some situations financial relationships with industry can be ethically
33 justifiable. When not accepting support from a commercial source or not permitting participation
34 by individuals who have financial interests in the educational subject matter would significantly
35 undermine medicine's capacity to ensure that physicians have access to appropriate, high-quality
36 CME, it can be acceptable to permit such support or participation. In these situations, vigorous
37 efforts must be made to mitigate the potential influence of financial relationships.

38
39 *Mitigating Potential Influence*

40
41 While there should be a presumption that physicians who organize, design, develop content, or
42 teach in CME should not have concurrent financial ties to industry related to their CME
43 responsibilities, it is important to recognize that not all relationships with industry are equally
44 problematic. A relationship that is only indirectly related to an educational activity, modest in
45 scope, or distant in time is not likely to adversely affect—or be perceived to affect—the activity in
46 question. For example, having once conducted sponsored research or accepted a modest
47 honorarium for speaking on behalf of a company would not necessarily create such clear potential

1 for bias as to preclude an individual with the appropriate expertise from developing content or
2 serving as a faculty member for a given CME activity.[41]

3
4 Financial relationships that are direct or substantial, however, have significant potential to
5 undermine confidence in educational activities, even if they do not actually compromise those
6 activities. Examples of a direct or substantial financial interest include ownership or equity
7 interest in a company that has an interest in the educational subject matter of a CME activity or
8 royalties or ongoing compensated relationships (e.g., consulting arrangements or service on
9 scientific advisory bodies or speakers bureaus).[4] Relationships that involve fiduciary
10 responsibilities on behalf of the funder (such as service on a corporate board of directors) or
11 decision-making authority in financial matters can be similarly problematic.[42] In such situations,
12 ethically strong practice requires that steps be taken to mitigate the possible influence of financial
13 relationships on educational activities.

14 15 PRINCIPLES FOR SUSTAINING TRUST

16
17 The goal of mitigation is to promote—and enhance confidence in—the integrity of continuing
18 professional education. Commitment to transparency, independence, and accountability enables
19 physicians to achieve that goal, whatever role they may play in CME. Moreover, being transparent
20 about financial relationships that have the potential to influence CME and forthcoming about what
21 steps have been taken to minimize possible influence supports physician-learners in exercising
22 critical judgment individually as “consumers” of CME.

23 24 *Transparency*

25
26 As the ACCME Standards for Commercial SupportSM recognize, transparency—i.e., disclosing the
27 existence of a financial relationship—is a necessary first step in mitigating the potential of financial
28 relationships to create bias (or the appearance of bias),[7] but it is not sufficient and may even have
29 perverse effects. Disclosure places the burden on learners themselves to determine how skeptical
30 they should be about possible bias in an educational activity.[43] To the extent that disclosure
31 fosters the impression that the presenter is particularly honest and trustworthy, it can encourage
32 false confidence in the activity. To the extent that the presenter believes disclosing a financial
33 relationship is adequate to mitigate its potential influence, he or she may be less circumspect in
34 ensuring content is free of such influence.

35
36 While transparency is essential, disclosing financial relationships is necessary but not sufficient to
37 mitigate the potential for influence in CME.

38 39 *Independence*

40
41 Taking concrete steps to ensure that CME is independent and objective is equally important.
42 Creating a “firewall” between funders and decisions about educational goals, content, faculty,
43 pedagogical methods and materials, and other substantive dimensions of CME activities can help
44 protect the independence of professional education. Both ACCME and the Inspector General of
45 the Department of Health and Human Services have recommended clearly separating decisions
46 about funding from substantive decisions about CME activities,[7,19] and many organizations are
47 developing models, such as “blind trusts,” to do so.[e.g.,44,45] Support of individual CME
48 activities by multiple, competing funders may also help diffuse the potential influence of any one

1 funder. Carrying out educational needs assessments prior to seeking or accepting commercial
2 support or identifying faculty can similarly enhance the independence of the planning process and
3 resulting CME programming. Likewise, having prospective peer review of a presentation (review
4 of slides or other forms of communication in advance of the presentation by an objective and
5 independent expert who has the power to require changes prior to the public showing) can help
6 ensure that the presentation is free of commercial bias.

7
8 *Accountability*

9
10 Physician-learners, patients, the public, and the medical community as a whole should be able to be
11 confident that physicians who organize, design, develop content, or teach in CME will uphold
12 principles of transparency and independence. The expectation that physicians involved in CME
13 will hold themselves accountable to address the potential that financial relationships with industry
14 have to influence professional education is a cornerstone of self-regulation. That responsibility can
15 be greatly enhanced by the efforts of accrediting and certifying bodies, but it cannot be supplanted
16 by them. In particular, physician leaders in CME should be able and willing to discuss how the
17 principles of transparency and independence have been applied in the educational activities with
18 which they are involved or over which they have decision-making authority.

19
20 *Exceptional Cases*

21
22 At times it may be impossible to avoid a financial interest or extraordinarily difficult or even
23 impossible to mitigate its potential impact on an educational activity. For the most part, accepting
24 support from a company or permitting participation by an individual when there is an irreducible
25 financial interest would not be ethically acceptable. However, in certain circumstances, it may be
26 justifiable.

27
28 Such circumstances include instances when accessible, high-quality CME cannot reasonably be
29 carried out without support from sources that have a direct financial interest in physicians' clinical
30 recommendations, such as activities that require cadavers or high-cost, sophisticated equipment to
31 train physicians in new procedures or the use of new technologies. Similarly, in the earliest stage
32 of adoption of a new medical device, technique, or technology the only individuals truly qualified
33 to train physicians in its use are often those who developed the innovation. These individuals may
34 have the most substantial and direct interests at stake, whether through employment, royalties,
35 equity interests or other direct financial interests in the adoption and dissemination of the new
36 technology. Physicians who organize CME should be transparent about what considerations led
37 them to decide to permit an individual with a problematic financial interest to participate in a
38 particular CME activity to ensure that such decisions are justifiable and persuasive to the
39 professional community at large.

40
41 *Putting Principles into Practice – The Exercise of Judgment*

42
43 Inevitably, putting principles of transparency, independence, and accountability into practice calls
44 for the exercise of judgment. It requires knowledge of the particular circumstances and thoughtful
45 deliberation. Yet this is no different from the kinds of judgments physicians routinely make in the
46 context of caring for patients and applying other portions of the *Code of Medical Ethics* to their
47 daily practice.

1 One approach is to reflect on what “consumers” of CME (which arguably includes patients and the
2 broader professional community, as well as individual physician-learners) would want to know to
3 exercise their skills of critical judgment; that is, to make well-considered judgments for themselves
4 about the objectivity and quality of a CME activity, its faculty, and its educational content. Such
5 factors might include not only the existence of a financial interest(s), but equally the source of that
6 interest, the type of interest (such as honoraria, consulting fees, equity, stock options, royalties),
7 and the magnitude of the interest, e.g., dollar amount to the nearest \$1,000, as currently required by
8 the North American Spine Society.[46]

9
10 Similarly, consumers of CME could reasonably want to know how the potential influence of a
11 financial interest has been addressed to protect the independence of the activity; or consumers may
12 want to know on what grounds an individual who has a direct, substantial, and unavoidable
13 financial interest has been permitted to participate in a CME activity. In the latter case, for
14 example, reasonable decision-making criteria might include that the dissemination of the device,
15 technique or technology will be of significant benefit to patients and to the public and the
16 professional community; that the individual is uniquely qualified as an expert in the relevant body
17 of knowledge or skills; that the individual discloses the source, nature, and magnitude of the
18 specific financial interest at stake; that there is demonstrated, compelling need for the specific
19 CME activity; that all feasible steps are taken to mitigate influence; and that this expert’s
20 participation in dissemination will, eventually, enable those without such financial interests to take
21 on the educational role. An individual might be considered “uniquely qualified” when he or she is
22 the only expert (or one of a few) who has significant knowledge about or experience in treating a
23 rare disease or was involved in the early development or testing of a new treatment, device, or
24 technology. A “compelling need” for a particular educational activity may be present when a new
25 therapy becomes available to treat a disease present in the local community for which the new
26 treatment represents a substantial improvement.

27 The need to rely on “conflicted expertise” can be affected by local conditions—CME in small or
28 rural communities, for example, may not always have ready access to experts who are free of
29 problematic ties to industry. In any event, when a substantial body of peer-reviewed evidence has
30 evolved in a given subject area, or when a cohort of individuals without direct, substantial interests
31 has become experienced in using a new medication, device, or technology and is available to teach,
32 using a “uniquely qualified” expert becomes less justifiable.

33
34 As the professional community gains experience, it is to be expected that consensus will coalesce
35 around core interpretations. As Harvard Medical School notes in its conflict of interest policy:

36
37 These classifications are not intended to serve as a rigid or comprehensive code of conduct or
38 to define “black letter” rules with respect to conflict of interest. It is expected that the
39 guidelines will be applied in accordance with the spirit of the mission of Harvard Medical
40 School in education, research and patient care. By this process, it is expected that a common
41 institutional experience in the application of these guidelines will gradually evolve.[47]

42
43 We expect that a similar shared understanding of how principles of transparency, independence,
44 and accountability should apply to financial relationships with industry in continuing medical
45 education will evolve for the medical profession.

1 RECOMMENDATION

2
3 The Council on Ethical and Judicial Affairs recommends that the following be adopted and the
4 remainder of this report be filed:

5
6 In an environment of rapidly changing information and emerging technology, physicians must
7 maintain the knowledge, skills, and values central to a healing profession. They must protect
8 the independence and commitment to fidelity and service that define the medical profession.

9
10 Financial or in-kind support from pharmaceutical, biotechnology or medical device companies
11 that have a direct interest in physicians' recommendations creates conditions in which external
12 interests could influence the availability and/or content of continuing medical education
13 (CME). Financial relationships between such sources and individual physicians who organize
14 CME, teach in CME, or have other roles in continuing professional education can carry similar
15 potential to influence CME in undesired ways.

16
17 CME that is independent of funding or in-kind support from sources that have financial
18 interests in physicians' recommendations promotes confidence in the independence and
19 integrity of professional education, as does CME in which organizers, teachers, and others
20 involved in educating physicians do not have financial relationships with industry that could
21 influence their participation. When possible, CME should be provided without such support or
22 the participation of individuals who have financial interests in the educational subject matter.

23
24 In some circumstances, support from industry or participation by individuals who have
25 financial interests in the subject matter may be needed to enable access to appropriate, high-
26 quality CME. In these circumstances, physician-learners should be confident that that vigorous
27 efforts will be made to maintain the independence and integrity of educational activities.

28
29 Individually and collectively physicians must ensure that the profession independently defines
30 the goals of physician education, determines educational needs, and sets its own priorities for
31 CME. Physicians who attend CME activities should expect that, in addition to complying with
32 all applicable professional standards for accreditation and certification, their colleagues who
33 organize, teach, or have other roles in CME will:

- 34
35 (a) be transparent about financial relationships that could potentially influence educational
36 activities.
- 37
38 (b) provide the information physician-learners need to make critical judgments about an
39 educational activity, including:
- 40
41 (i) the source(s) and nature of commercial support for the activity; and/or
42 (ii) the source(s) and nature of any individual financial relationships with industry related
43 to the subject matter of the activity; and
44 (iii) what steps have been taken to mitigate the potential influence of financial
45 relationships.
- 46
47 (c) protect the independence of educational activities by:

- 1 (i) ensuring independent, prospective assessment of educational needs and priorities;
2 (ii) adhering to a transparent process for prospectively determining when industry support
3 is needed;
4 (iii) giving preference in selecting faculty or content developers to similarly qualified
5 experts who do not have financial interests in the educational subject matter;
6 (iv) ensuring a transparent process for making decisions about participation by physicians
7 who may have a financial interest in the educational subject matter;
8 (v) permitting individuals who have a substantial financial interest in the educational
9 subject matter to participate in CME only when their participation is central to the
10 success of the educational activity; the activity meets a demonstrated need in the
11 professional community; and the source, nature, and magnitude of the individual's
12 specific financial interest is disclosed; and
13 (vi) taking steps to mitigate potential influence commensurate with the nature of the
14 financial interest(s) at issue, such as prospective peer review.

15
16 (New HOD/CEJA Policy)

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

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