Public policy tries to promote appropriate drug use by allowing firms to market drugs in interstate commerce only for uses that the Food and Drug Administration (FDA) has found to be safe and effective. Because of their medical knowledge, physicians are authorized to prescribe drugs even for uses unapproved by the FDA. Nevertheless, physicians have relied on drug firms for information on appropriate prescribing despite the inherent tension between drug firm dissemination of information to promote sales and rational prescribing. In the past, physicians often relied particularly on drug firm advertising for information on drug use. Today, physicians rely on drug firms to finance continuing medical education (CME). A historical review reveals connections between these two different ways commercial interests have influenced the information that physicians receive and points the way to needed reforms.

Drug Information from Advertising, Commercial Publications, and Detailers

Writing in the *Journal of the American Medical Association* (JAMA) in 1908, AMA president George H. Simmons accused drug firms of flooding medical journals with promotional material in the guise of articles. “The fact that the Abbot Alkaloidal Company spends thousands of dollars in advertising its products in the various journals that carry these ‘original articles’ and ‘testimonials’ might explain why they were published.”

He also said that Abbott’s publication, the *American Journal of Clinical Medicine*, was merely a means of promotion. To influence prescribing, pharmaceutical firms also developed sales representatives known as medical detailers, to meet with physicians, tell them about new drugs, and pitch their products. Early in the 20th century, detailers became the main source of drug information for physicians, prompting professional leaders to advocate reforms. In 1929, speakers at an AMA symposium proclaimed “the need to replace the detail man as the main source of instruction in the use of medicines by professional, noncommercial sources of information.” They decried the lack of an independent “guide in judging the claims of clever advertising and the detail men,” the financial links between pharmaceutical firms and physicians writing articles on the drug’s effectiveness, and the compromised ability of medical journals to assess drugs as a result of “receiving slices of the [advertising] appropriation.”

Nevertheless, advertising continued to be confused with education. From 1959-1961, Senator C. Estes Kefauver (D-Tenn.) investigated the pharmaceutical industry and championed enactment of the Food, Drug and Cosmetic Act (FDCA) 1962 amendments. Testifying in 1959, Tobias Warner, marketing director for Smith Kline & French, said “pharmaceutical promotion differs from consumer promotion to the laity [because it] ... is dedicated almost as much to educating and imparting essential information as it is to selling.” Dr. Austin Smith, president of the Pharmaceutical Manufacturers’ Association (PMA) made the same claim in his testimony.

However, Dr. Charles May, editor of the AMA journal *Pediatrics*, who served on the AMA Council on Drugs, criticized this view in his article “Selling Drugs by Educating Physicians.” He warned that the “independence...
of physicians is ... threatened by ... drug manufactur-
ers ... [that] promote their products by assuming an
aggressive role in the education of doctors. At the
Kefauver hearings he testified that advertising was
"the masquerading of promotion as education" and
that “pharmaceutical promotion cannot be accepted as
[a] trustworthy means of bringing accurate informa-
tion ... to physicians.” He cited advertisements in journ-
als (including JAMA) that made false, misleading,
or unsubstantiated claims; one asserted a drug was
safe after an article in the same journal warned of its
risks. Dr. May criticized industry subsidies of medical
journals, conferences, and the medical education. He
charged that “medical organizations are given moneys
to support a large part of their activities and then are
claim that advertising was educational, and argued
until 1969 that JAMA advertising revenue should
therefore not be taxed. After the FDA prosecuted one
drug firm for false advertising, however, the AMA said
that accuracy of drug advertising was a manufacturer
responsibility, acknowledging that it did not ensure
accuracy of materials it deemed educational. Mis-
leading drug advertising continues today.

After World War II, drug firms also increased finan-
cial support for professional societies and educa-
tion. In a 1953 article titled “Interdependence of the
Medical Profession and the Pharmaceutical Industry,”
Hoffmann-LaRoche’s Dr. Elmer Sevringshaus reported
requests for drug firms to make “larger contribu-
tions to medical education” and that “universities and
larger hospitals are asking ... for undesignated grants
[for use] at the discretion of the staff...” By 1967, the
Department of Health and Human Services (DHHS)
reported that “many of the functions of the AMA
and other national, state and local medical groups
are financed ... by PMA member companies.” Some
physicians became alarmed. In 1969 Senate hearings,
Dr. James Faulkner proclaimed, “No organization
which purports to represent the medical profession
should [be] ... largely dependent on ... drug advertis-
ing.” In 1971 Senate testimony, Dr. Robert Seidenber
noted that opponents of national health insurance
had warned about dangers of third party payers, but

INDEPENDENT

In the past, physicians often relied particularly on drug firm advertising for
information on drug use. Today, physicians rely on drug firms to finance
continuing medical education (CME). A historical review reveals connections
between these two different ways commercial interests have influenced the
information that physicians receive and points the way to needed reforms.

in a poor position to criticize practices that infringe on
the prerogatives of the medical educator.

Other Kefauver hearing testimony revealed that some journals, such as Current Therapeutic Research,
were mainly marketing vehicles. Drug firms paid to
have their manuscripts published without peer review,
purchased expensive reprints, and distributed them to
“educate” physicians. Some journals “refused to pub-
lish articles criticizing particular drugs ... lest advertise-
sing suffer.”

The AMA tried to balance practice based on knowl-
edge with reliance on drug advertising, thereby creating
“internal schisms” between “ties to the pharmaceutical
industry” and “rational therapeutics.” Since 1847, the
AMA had condemned secret nostrums — drugs with
undisclosed ingredients marketed to laymen and phy-
sicians — yet depended on advertising them to finance
its journal. After 1900, AMA revenue from member-
ship dues increased, which allowed it to end its depen-
dence on advertising secret nostrums and to reform
drug marketing. In 1905, the AMA began to grant
seals of approval to drugs meeting several conditions.
Manufacturers had to list all ingredients on labels (the
accuracy of which the AMA confirmed through test-
ing), only market to physicians, and comply with other
rules. The AMA ceased advertising all drugs it did not
approve, but recouped that lost income because what it
called ethical drugs could now only advertise in medi-
cal journals. JAMA income grew until the late 1940s,
when other physician journals offered advertisers an
alternative. Then JAMA advertising declined.

From 1950 to 1956, the AMA employed Ben Gaf-
fin and Associates for advice on increasing its journal
advertising. In one report, Gaffin wrote, “The AMA can
... make advertising a ... force for helping the prac-
ticing MD keep current on developments which have
occurred after he has completed his formal medical
training.” The AMA then made numerous changes
to make JAMA more attractive for drug advertising.
Whether for that reason or others, the AMA ended its
program of approving drugs in 1955 and then phased
out its strict review of drug advertising. JAMA adver-
tising then rebounded. The AMA supported pharma's
that the drug industry was not ‘a more acceptable ... bedfellow.”

The Rise of Continuing Medical Education

Pharma and the AMA claimed that advertising was educational when physicians received little post-residency training. Few medical schools offered courses for practitioners until the 1940s.20 Physician opposition prevented the AMA from requiring CME, but starting in 1968, it granted CME recognition awards. In 1971, state medical societies began to require members to receive CME, but there was no accreditation or evaluation of CME.21 Starting in 1971, the AMA offered recognition awards only to organizations accredited by its Council on Medical Education, and the Council subsequently delegated certain accreditation activities to state medical societies. Along with others, in 1977, the AMA founded the Liaison Committee on Continuing Medical Education (LCCME) to take on its role in CME accreditation.22

By 1976, industry-funded CME attracted the attention of Senator Gaylord Nelson (D-WI) who chaired extensive hearings on the pharmaceutical industry and medical education.23 Dr. Richard Crout, M.D., Director of the Food and Drug Administration, Bureau of Drugs, testified that extensive drug industry underwriting of postgraduate education developed in the last decade.24 Industry funding created bias, he said, because “…the industry sponsor can choose from among the many medical authorities on any given topic to support only those whose views already coincide with the interests of the sponsor.”25 Senator Nelson recalled the warning of Dr. Charles May 15 years earlier regarding drug company promotion through medical education.26 He asked, “How can we trust any program sponsored by the industry as being educational rather than promotional?”26 He pursued the implications by questioning “whether drug companies ... should be allowed by hospitals and physicians to intrude into the education business in any fashion whatsoever ..., would it not be much better if ... all of the post medical education were in the hands of the scientific community and the medical schools ...?”27

In 1980, the AMA and six other organizations formed the Accreditation Council for Continuing Medical Education (ACME) as the successor to the LCCME.28 Since then, the ACCME accredits entities to offer CME and also authorizes some other institutions and organizations to accredit CME providers. In addition, the ACCME develops criteria to evaluate educational programs, which the ACCME and state accrediting bodies use in accrediting CME providers. States that require physicians to obtain CME credits specify that they do so from organizations that they or the ACCME accredit.

At the time the ACCME began, eight states required CME for physicians.29 There were a few commercial firms that provided CME (called Medical Education and Communication Companies or Medical Education Service Suppliers). They included publishers, insurers, a managed care trade group, and the drug firm Eli Lilly. Commercial CME providers often also performed pharmaceutical marketing or public relations work. Most CME, however, was organized by medical schools and medical societies, although they often used medical education companies to help develop the program materials.

Eager to avoid paying for CME themselves, physicians accepted commercially funded CME. No one set CME requirements regarding what topics should be offered or content of curricular, so commercial funding determined the topics offered. As drug firms increased funding, for-profit accredited CME providers grew from ten in 1990 to 68 by 2000 and 158 by 2006.30 In 2006, the ACCME accredited 730 providers directly and 1684 providers indirectly using 46 organizations that the ACCME recognizes as state-based accrediting organizations that follow ACCME standards.31 Accredited providers include: physician membership organizations, for-profit firms, medical schools, hospitals/health care systems, nonprofit organizations, governmental entities, insurers, and other unclassified entities. In 2006, they produced 149,889 CME activities. In addition to accredited CME, pharma and commercial interests organize activities that they deem to be CME, even though they are not accredited.

In 1990, Senator Edward Kennedy (D-MA) chaired hearings on pharmaceutical industry marketing that documented, among other questionable activities, the use of CME to market drugs. David Jones (formerly vice-president of Abbot Laboratories and CIBA-GEIGY executive director for government and public affairs) testified that “[m]edical education today is now determined by what the marketing department wants...” “Promotion disguised as education is sponsored by bogus organizations” on behalf of marketing departments and routinely promotes “unapproved and unproven” drug uses. Furthermore, “Doctors ... are recruited to publish helpful articles which are produced by company medical writers who assure that the marketing messages are featured.”32

In 1991, the FDA concluded that drug companies used CME to promote drugs, sometimes even for unapproved uses.33 Some programs recommended calcium channel blockers, approved to control arrhythmia, for use after heart attacks; this off-label use resulted in tens of thousands of deaths according to the FDA.34
The promotion of unapproved drug uses through CME continues. In 2005, Serono labs paid $704 million as part of a settlement of a government suit that alleged it used education grants to market Serostim, a drug approved to treat AIDS, for off label uses. The Wall Street Journal reported that in 2006, Glaxo SmithKlein funded a CME program that advocated the use of its herpes drug, Valtrex, to treat neonatal herpes, an unapproved use.

Drug companies publicly maintained that CME providers were independent, but one individual reports that these companies sometimes refer to CME providers as their “agency,” the same term they use to refer to medical communication companies who develop promotional and advertising materials. Moreover, CME providers traditionally sought funds from one firm per program, because, as a manager of a CME provider explained to me, drug firms believed a provider supported by two or more firms with competing drugs would have a conflict of interest. Drug firms typically funded CME from their marketing budgets and often played a major role in its development. They chose the faculty, often selected individuals with whom they had financial ties, supplied them with slides and written materials, and sometimes changed the speaker’s text over their objection. They linked grants to hospitals placing their drug on its formulary. CME providers attracted support by saying they helped promote sales. In 2001, one wrote it creates “educational programs ... designed to gain a higher rate of acceptance at the launch of a new product and to increase return on investment.”

Drug firm spending on accredited CME and other so-called educational programs has grown vastly in recent years. Industry spending on accredited CME was $302 million in 1998, over $1.071 billion in 2004 (with $197 million more for advertising), and over $1.5 billion in 2007, constituting over half of all funding for CME. Moreover, less than 9 percent of the nearly 500,000 physician meetings and symposia in 2006 were accredited CME; 89 percent of all unaccredited meetings — which sponsors usually claim are educational — were closely associated with drug firms.

Commercial interests — mainly pharmaceutical and medical device firms — generate the overwhelming share of income of for-profit CME providers. However, they also supply more than half the income for not-for-profit CME providers. In 2008, commercial interests funded 71 percent of commercial providers’ income, but they also funded over 59 percent of medical school CME income, and over 47 percent of physician organization CME income. Indeed, physician organizations earned higher rates of profit from their CME revenue (32 percent) than did commercial providers (26 percent).

A lawsuit settled in 2005 illustrates some marketing/CME abuses. Four years after Parke-Davis introduced Neurontin (Gabapentin), 90 percent of its prescriptions were for unapproved uses. Parke-Davis funded studies on unapproved uses and publicized positive findings but not those unfavorable. It hired medical education companies to produce articles, review papers, and letters that advocated off-label uses and paid physicians to sign as the authors. It sponsored studies as a means to teach physicians drug doses for unapproved uses. It employed a firm to market Gabapentin while also funding it for CME on topics for which Gabapentin could be used. Parke-Davis employees met with the CME provider to develop the curricula; the faculty advocated Gabapentin for unapproved uses.

Oversight of Commercial Support for CME

Until 1990, drug firms routinely paid physicians’ expenses for professional meetings registration, travel, and lodging. Then, seeking to prevent stricter federal oversight, the AMA and Pharmaceutical Research and Manufacturer’s Association (PhRMA) voluntary guidelines prohibited such funding. Nevertheless, in 2004, over a quarter of doctors reported commercial firms paid their expenses. By 1991, when the FDA planned to curb the use of CME to promote drugs for unapproved uses, several studies concluded there was CME funding bias. Yet medical societies opposed regulation and funding restrictions. Kirk Johnson, senior vice president of the AMA, told Medical Marketing & Media, “industry support of education is ... critically important ... we’ll die for that position, and ... vigorously defend it in our meetings with [the FDA] Commissioner.”

The FDA’s 1992 draft policy held that drug firm-controlled programs could not recommend unapproved drug uses, but that independent CME could. It considered a drug company funded program independent if the provider had a contract that granted it control and specified that the program was not for promotion. Funders could recommend individuals as faculty, if the program disclosed this. CME providers and faculty had to disclose their financial relationships with commercial funders. Faculty that discussed off-label drug uses had to state that they were not FDA approved. The FDA relied on the ACCME to monitor compliance. In 1992, the ACCME revised its Standards for Commercial Support to follow FDA standards.

Organized medicine and pharma criticized the draft and in 1997, the FDA issued weaker final guidelines. The FDA said it would not prosecute CME providers

810
that only failed to meet one of its criteria for independence and promoted unapproved drug uses. The Washington Legal Foundation (WLF), a pro-business, free-market advocacy group, sued the FDA. It argued that the CME guidelines, and other guidelines that restricted drug firms from disseminating articles on off-label drug uses, violated free speech. In 2000, a trial court sided with the WLF. In arguments before the appeals court, the FDA said it no longer held that the FDCA prohibited drug firms from disseminating articles on off-label drug uses and was withdrawing both these and the CME guidelines.

Since 2005, ACCME guidelines disqualify CME faculty and program managers with financial ties to commercial firms unless they have independent peers review the program materials to rule out bias. The guidelines say that other measures might resolve the conflict of interest but that disclosure is insufficient.

Meanwhile, the Office of Inspector General (OIG), which combats kickbacks and fraud in Medicare and Medicaid, turned its attention to drug firms. In 2002, it proposed as a regulation, guidelines that restricted pharma funding of professional activities. In response, the AMA and PhRMA beseeched the OIG to drop restrictions on funding CME, research, and scholarships; 25 medical organizations (including the American College of Physicians, the American College of Surgeons, and the Association of American Medical Colleges) made similar requests. Several specialty societies said all pharma grants to medical societies should be allowed.

The OIG 2003 final guidelines adopted these suggestions, stating “support for educational activities sponsored and organized by medical professional organizations raise little risk of fraud or abuse.” However, following the FDA, it said that commercial funders risk prosecution when they control CME. It recommended that drug firms separate marketing from grant making. Since then, separate entities organize CME and marketing. Sometimes, however, one company owns both a CME provider and a drug marketing firm. Still, the ACCME appeared to allow providers to show potential and current funders their draft program and receive suggestions. Its 2004 Standards for commercial support said, “A provider cannot be required by a commercial interest to accept advice or services concerning teachers, authors, or participants or other education matters, including content, from a commercial interest as conditions of contributing funds or services” (emphasis added). That language does not prohibit commercial supporters from offering advice, CME providers from soliciting suggestions from them, or CME providers voluntarily following suggestions of commercial supporters. My interviews with CME providers indicated that these were common practices.

In 2007, the Senate Committee on Finance investigated industry-funded CME. Its report noted that the ACCME accreditation “relies … on information supplied by the CME providers … [yet it] detects… significant … noncompliance.” It concluded that ACCME standards were inadequate because the “provider can technically maintain ‘control’ of content … while continuing to accommodate suggestions from the companies that control their funding. Providers can ‘afford drug companies the ability to target their grant funding at programs likely to support sales of their products.”

In reply to the Senate Committee, the ACCME wrote in part, “The ACCME recognizes that CME can receive financial support from industry without receiving any advice or guidance, either nuanced or direct, on the content of the activity or on who should deliver that content” (emphasis added). Later, in answers to frequently asked questions, the ACCME interpreted its standards for commercial support to preclude providers soliciting suggestions or advice from commercial supporters or their showing commercial supporters draft programs before the CME activity occurred.

In 2009, an Institute of Medicine report on medical conflicts of interest in medical education, research and practice found that CME was “too reliant on industry funding” and so had “a narrow focus on products.” Moreover, an AMA Council on Ethical and Judicial Affairs report stated it is ethically preferable for medi-
cal organizations to avoid accepting funds for CME from firms with an interest in physician prescribing, but that accepting commercial support is permissible if the provider directs the program and discloses the funding source. The House of Delegates did not adopt that position, so it is not AMA policy. In an article discussing earlier AMA discussion of CME, Dr. Arnold Relman, former editor of the New England Journal of Medicine, wrote that neither the AMA House of Delegates nor the American Association of Medical Colleges (AAMC) Executive Council want “to cut off industry support of CME because ... they see no other source of funding...” This explanation also seems to explain the delegates recent decision.

Reforming the Financing of CME
Reform proposals abound. A common suggestion is that disclosing financial ties will resolve the problem. Yet noting conflicts of interest does not prevent or remove bias. Others urge stronger accreditation standards. However, the ACCME only accredits organizations, which then develop whatever CME they wish. It does not accredit CME programs or determine the topics offered or program content. And its oversight relies mainly on volunteers and self-reporting. The American Association of Medical Colleges propose that CME offerings be “externally spot-reviewed or audited for ... the presence of inappropriate influence.”

Some physicians argue that for-profit providers cater to the interests of commercial funders, and believe that only medical schools and medical societies should be accredited to sponsor CME. Certainly some commercial CME providers used to function as marketers. But that has changed and today CME providers are compromised because they depend on industry funding. But so do medical schools and medical societies.

All CME providers must develop programs that commercial interests find appealing if they want to receive commercial support. Others propose that drug firms pool contributions and collectively fund programs. That would prevent individual firms from choosing individual CME programs, but CME would still depend on commercial support. As one proponent admits, “Any industry-sponsored CME pool might still favor CME activities that generally promote interventions involving pharmaceuticals or devices.” Another option is to channel all contributions to an independent “central repository [which] ... would disburse funds to ACCME-approved programs.” Yet presumably firms would not contribute unless the central repository generally chose topics that they wanted. The ACCME suggests limiting accredited CME to topics chosen by a respected third party, but that alone does not specify funding among topics, or oversee curricula, and that still relies on discretionary support. Still another suggestion is that CME providers simply not accept any funding from commercial interests. This is unlikely to occur unless legislation prohibits CME providers from accepting funding from commercial interests. Moreover, that would not rule out commercial influence unless the legislation also prohibited CME providers from accepting funds from foundations and associations that received grants, advertising income, or other support from commercial interests.

A New Proposal
Contrasting CME with other medical education reveals the key problem. Accrediting organizations and governmental authorities establish curricula for undergraduate and graduate medical education. Medical schools do not offer courses based on what commercial interests voluntarily fund. Yet for CME, there is no required curriculum. CME topics are closely related to products of drug firms because it is financed by their voluntary contributions. One industry commentator suggests that there are areas of convergence of interest between business interests and health care system quality gaps. However, in its 2010 report, Redesigning Continuing Education in the Health Professions, the Institute of Medicine concluded that “funding should be directly aligned with the goals of driving improved quality of care and patient safety...” Furthermore, it notes that “without funding from conflicting sources, continuing education content would likely shift away from knowledge about specific drugs and devices.”

Organizations unaffiliated with commercial interests should develop required CME curricula based on assessments of problems that exist in medical practice, the educational needs of physicians, and which educational interventions will yield the most benefit. Public authorities should raise and allocate funds. Congress should impose a CME tax on commercial medical firms, insurers, medical facilities, and perhaps even physicians. A federal authority should allocate these funds to government-certified not-for-profit institutions created for the purpose of distributing these funds to independent entities that develop CME. Commercial interests should not be allowed to donate funds, even indirectly, for accredited CME. In short, CME providers should not be permitted to receive funds even from foundations, associations, or organizations that receive any grants, other income, or support from commercial interests.

How would the taxed entities pay for their increased expenses? They could either absorb it and lower their profits, or pass along the cost through increased
prices. American drug firms could easily absorb this cost; since the 1950s they have consistently earned higher profits than the Fortune 500 companies have. Of course, entities taxed might increase their prices to cover the expense. However, insurers already finance most medical spending and adding the cost of accredited CME would be relatively small. Support for CME totals around $2 billion annually, 0.0013 percent of national health care spending in 2008, about $6.58 per person. Having the public shoulder that burden through insurance is feasible. Moreover, improved CME would reduce inappropriate drug prescribing and improve the quality of care, a worthwhile change that might also lower medical spending.

In fact, public finance of CME would probably not increase much what the public already pays. Commercial interests already fund most CME. If they now pass on these costs in the price of their products, then insurers and the public already pick up the tab. In that case, doesn’t it make sense for the public to choose to use these funds and to ensure that CME is unbiased? And if commercial interests now absorb the cost of CME, why would that not also occur if they pay a CME tax — unless pharmaceutical marketing is incompatible with medical education?

Acknowledgements
Taya Mashburn provided research assistance. Hervé Maisonneuve provided helpful comments. Funded in part by a summer research grant from Suffolk University Law School, and Université de Rennes, l’Institut de l’Ouest: Droit et Europe, UMR CNRS 6262.

References
1. I develop the themes in this article, along with analysis of other financial conflicts of interest, in M. A. Rodwin, Conflicts of Interest and the Future of Medicine: The United States, France and Japan (New York: Oxford University Press, forthcoming February, 2011).
8. Id.
10. Subcommittee on Antitrust and Monopoly, Committee on the Judiciary, Administered Prices Drugs, U.S. Senate Hearings, vol. 18, 10, 338 (1960) (testimony of William B. Bean, Chair of the Department of Internal Medicine, University of Iowa Medical School).
23. Id., at 13919.
24. Id., at 13920.
25. Id., at 13913.
26. Id., at 13914.
27. Id., at 14015.
28. The organizations that founded and govern Accreditation Council for Continuing Medical Education (ACCME) are the
following: American Board of Medical Specialties; American Hospital Association; American Medical Association; Association of American Medical Colleges; Association for Hospital Medical Education; Council for Medical Specialty Societies; and Federation of State Medical Boards of the U.S.


32. Senate Committee of Labor and Human Resources, Advertising, Marketing and Promotion, 101st Congress (1990), at 174-175.


38. Personal communication from Anonymous to author (September 2007).

39. Personal communication from Mark Schaffer to author (October 2007).


41. Institute of Medicine, Redesigning Continuing Education in the Health Professions, supra note 21.


48. The FDA said CME programs are unlikely to be independent if: it focuses on a single product; a commercial firm owns the CME provider or employs it for marketing or sales, or recommends individuals who promote its products as faculty, or arranges program invitations or disseminates program materials through its marketing department; a provider is not financially viable without a single commercial firm’s support, has significant contacts with FDA-regulated firms, or previously organized programs that did not meet standards for independence.


50. See id. (Relman, 2001).


53. See, for example, American Association of Electro-diagnostic Medicine, Comment No. 55, American College of Rheumatology, American College of Chest Physicians, Comment No. 87, the Endocrine Society, Comment No. 106.


56. Standard 3.2.


60. The ACCME made this clear in its response to frequently asked questions on line, see, ACCME response to frequently asked questions regarding commercial support and independence, available at <http://www.accme.org/index.cfm/fa/faq.detail/category_id/667b726-627-431-99e9-14e7b621e78.cfm> (last visited September 30, 2010). However, the ACCME did not change its standards for commercial support, Standard 3.3, which states only that providers “cannot be required by a commercial interest to accept advice.”


69. See Morris and Taitsman, supra note 64, at 280.


74. Institute of Medicine, Redesigning Continuing Education in the Health Professions, supra note 21, at 73.

75. Id.


77. See Rodwin, supra note 1.

78. “Senate investigations found that pharmaceutical industry net profits after taxes from 1958-1959 were 21 percent. U.S. Senate Subcommittee on Antitrust and Monopoly, 1965, 278. Peter Temin analyzed the data from the FTC, SEC, and other studies and concluded that profits after taxes were between 17 percent and 19 percent from 1948 through 1973; see P. Temin, Taking Your Medicine, Cambridge: Harvard University Press, 1989); at 80-82. For other analysis of pharmaceutical industry profits, see M. Angel, The Truth About Drug Companies: How They Deceive Us and What To Do About It (New York: Random House, 2004).