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Peer Review of Continuing Medical Education Content: One Mechanism for Resolution of Conflicts of Interest

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Since the promulgation of the ACCME Updated Standards for Commercial Support in September 2004, providers have been challenged to go beyond disclosure to *resolve* COI. Now, nearing the November 2006 date when the updated standards will be used to determine accreditation status, it is becoming increasingly important to more clearly define the mechanisms that providers have implemented to resolve COI. This article focuses on peer review of CME content.

In accordance with Standard 2.3, providers must have implemented a mechanism to identify and resolve all COI prior to the education activity being delivered to learners. In October 2004, ACCME released frequently asked questions to assist providers with compliance with the updated Standards. That information included two examples of mechanisms that may be used to resolve COI. The following example of how to resolve COI while preserving *participation of experts with financial relationships* can be found on the ACCME web site *(www.accme.org, Ask ACCME, SCS 2.3):*

a. The conflict can be resolved by an *effective peer review of content* prior to presentation or publication to ensure the content is valid and aligned with the interest of the public. Various methods of peer review to validate content can be effective mechanisms for resolving conflict of interest. One way to resolve the conflict of interest is to have scientific abstracts or free-standing papers or articles peer reviewed or judged by commercially disinterested peers before they are accepted for presentation or publication.

b. In addition, requiring that all financial relationships be disclosed prior to an activity will alert participants (audience, readers) of the potential for conflict of interest and commercial bias. *Participants could be asked to evaluate the objectivity of the presentation* or publication, and to identify any perceived commercial bias.

c. Also, presenters, authors, planners and reviewers could be *instructed to reference the best available evidence.*

ACCME clarifies that peer review is a mechanism that may be used to *identify* commercial bias; however, corrective action must be taken in order to *resolve* the conflict. This is emphasized in the following statement *(www.accme.org, Ask ACCME, SCS 2.3)*:

> If [peer review is] used before the activity, it is a screening process—and *action* needs to be taken to revise the content if commercial bias or invalid content are identified. If used after the activity, it is a monitoring process—and could produce information on the effectiveness of the provider's mechanism to resolve conflicts of interest. System improvements may follow, if warranted.

During discussions with CME stake holders in recent months, I found there to be variations both in what is meant by the term *peer* and in the processes associated with peer review. This impression formed the basis of a set of questions about the current application of peer review, including:

1. Is content being peer reviewed?
2. How is it being done and by whom?
3. What aspects of compliance are being documented by the process?

As a first step to better understanding the current role of peer review in the development and implementation of CME activities, three online surveys were conducted with subsets of accredited providers, pharmaceutical companies and CME consultants. The surveys addressed the same issues from each of the different perspectives. The goal was to get a point-in-time snapshot of where stakeholders are on the continuum of change regarding the adoption of peer review of CME content.

This article addresses survey findings, with respect to the providers' use of peer review as a mechanism for COI resolution, and focuses on who is performing the reviews, and what aspects of compliance are being documented by the peer review process. It is important to note that while the data is interesting, some sample sizes are small.

Methodology

Accredited Provider Survey

The accredited provider survey was emailed to 429 individuals at 265 organizations, representing all provider types, in spring 2006. Individuals were past participants of industry conferences, selected primarily on their organizational title. A reminder email was sent to

those who had not yet responded. A total of 368 emails were delivered and 133 responses from 122 organizations were received—for an individual response rate of 36 percent, and an organization response rate of 46 percent. The survey consisted of 13 questions and an open-ended comment section.

Consultant Survey

The consultant survey was emailed to 27 industry consultants in spring 2006. Individuals were past participants and speakers at industry conferences who identified themselves as consultants; all emails were delivered. A reminder email was sent to those who had not yet responded. A total of 13 responses were received for a response rate of 48 percent. The survey consisted of 10 questions and an open-ended comment section.

Pharmaceutical Company Survey

This survey was emailed to 117 individuals at 32 companies in spring 2006. Individuals were past participants of industry conferences, selected primarily on their title in their organization. A reminder email was sent to those who had not yet responded. A total of 113 emails were delivered, and 21 responses from 12 companies were received—for an individual response rate of 17.9 percent, and a company response rate of 37.5 percent. The survey consisted of 10 questions and an open-ended comment section.

Provider Respondents by Provider Type

Publishing/Education Company	32%
Physician Membership Organization	26%
School of Medicine	17%
Hospital/Health Care System	14%
Nonprofit Organization	4%
Government/Military Organization	1%
Insurance/Managed Care Company	1%
Other	5%

Provider Respondents by Organizational Title

CME/CE Director	41%
Organization Leadership	20%
CME/CE Manager	18%
CME/CE Leadership	15%
Compliance Officer	4%
Other	2%

Pharma Respondents by Organizational Title

Grant Review/Medical Affairs	48%
CME Compliance Officer	19%
Company Leadership	14%
Other	19%

Results

The results revealed that the vast majority (90 percent) of *providers* surveyed are conducting peer review of CME content, currently implementing a peer review process, or they have either a case-by-case content review process or content review as a second step for conflict resolution. Only eight percent said that they have no plans to implement a peer review process at their organization; two percent indicated *other*.

Seventy-seven percent of *consultant* respondents indicated that they *strongly recommend* the inclusion of peer review of CME content to their clients; 23 percent neither recommend nor discourage it.

What Mechanisms are Being Used to Conduct the Review?

The mechanisms for conducting the reviews varied widely among providers and consultants alike. All provider respondents, except those who indicated that they have no plans to implement a peer review process, were asked to select or provide their primary method of peer review:

- Internally, via contract with an external health care provider(s)
- Via contract with a physician group
- Externally, with an independent third party
- Other.

Forty-four percent of respondents indicated that their process is an internal one. Seventeen percent said that they utilize an external independent third party to conduct their reviews; 10 percent contract with physician groups; and nine percent contract with external health care providers. However, 20 percent selected *other* and specified their particular mechanism. This group included:

- Volunteer experts
- Clinical department activity directors
- Physician membership
- Physician leadership
- Physician peers
- Independent advisory board
- Physician volunteers
- Physician committee
- Association members
- External small physician group
- CME committee
- Activity program committee
- Internal health care provider
- A combination of CME/CE staff and university faculty
- Usually done by someone on the editorial board or advisory panel
- Physician editor
- Multiple methods, internal and external.

Consultants were also somewhat divided on the issue: 50 percent recommended that peer review be conducted externally—33 percent by an independent third party, and 17 percent by a contract with one or more external health care providers. Twenty-five percent recommended internal review, and the remaining 25 percent indicated *other* (specifically: internal physician experts, volunteer committee and staff, and *any way that works*).

Pharma participants were asked if their grant request committee looks most favorably on peer review conducted internally; via contract with an external health care professional; via contract with external physician group; externally by an independent third party; or no preference. Sixty-seven percent indicated that their grant committee would look most favorably on peer review conducted externally by an independent third party; twenty-five percent had no preference and eight percent chose *other* and specified *any means that is truly evidence-based.*

Who is Performing the Reviews?

Differences, regarding who conducts the reviews, also appear among *providers*. While some providers offered some insight via their comments to the previous question, here they were asked to identify the profession of reviewer(s) of CME content by indicating all that apply: nurse, pharmacist, physician (nonspecialist), physician specialist for subject matter, other health care professional, and other. Ninety-one percent of those who responded use physician subject matter specialists in some capacity; 45 percent utilize physicians (nonspecialists); 30 percent also utilize nurses; 23 percent also employ pharmacists; 16 percent use other health care professionals; seven percent specified via comment that they depend on CME/CE department staff members and educators.

Consultants were somewhat less divided. Fifty percent indicated that they recommend utilizing a physician specialist for the subject matter; 25 percent recommend physician (nonspecialist); 17 percent chose *other,* specifying *best available expert* and a *representative of the target audience who is a content expert*; eight percent recommend utilizing a nurse.

Pharma respondents were asked to indicate the type of reviewer their grant request committee looks upon most favorably. Forty-two percent indicated physicians: physician specialist for subject matter (33 percent) or physician, nonspecialist (8 percent); 33 percent chose other, specifying physician or nonphysician specialist, depends on needs of the learner, depends on audience, depends on the topic/audience; 25 percent indicated no preference. (Note: figures do not add up to 100 percent due to rounding.)

What's Being Documented by the Peer Review Process?

Providers were asked to identify all of the compliance areas documented by their peer review process. They strongly identified these five areas, listed in order of importance:

- Balance, objectivity and absence of commercial bias (98 percent)
- Content validation (88 percent)
- Scientific rigor (88 percent)
- Clinical practice/patient care recommendations are based on evidence that is accepted within the profession (84 percent)
- Alignment of needs, objectives and content (78 percent).

Consultants were asked to indicate whether the documentation listed was essential, important, helpful or unnecessary. Their responses mirrored the same five areas strongly identified by providers, and in very nearly the same order:

1. Balance, objectivity and absence of commercial bias
2. Scientific rigor
3. Content validation
4. Alignment of needs, objectives and content
5. Clinical practice/patient care recommendations are based on evidence that is accepted within the profession.

The three areas of documentation of most interest to the *pharma* respondents were:

1. Balance, objectivity, and absence of commercial bias
2. Alignment of needs, objectives and content
3. Scientific rigor.

Summary

The survey data revealed the pervasive use of peer review as a mechanism for improving the integrity of CME activities, and highlighted the variation among providers in their approach. Comments indicated that differences in attitudes about, and approaches to, peer review exist among provider types, as well as among pharma and consultant respondents. This survey data is intended to represent a starting point. Further research will be necessary to validate and expand the findings. Given the number of providers employing peer review, it is important to begin to identify best practices in what is a very important part of the *resolution of COI* process. Next steps may include a survey on the methodologies used by providers and the use of survey tools specific to each provider type.

Thank you to those who participated in the survey, as well as Jacqueline Parochka, EdD and Richard Tischler, PhD for their contributions.

Complete survey results can be found at: www.cmepeerreview.com.