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September 12, 2008

Murray Kopelow, MD, MS(Comm), FRCPC
ACCME Board of Directors
Accreditation Council for Continuing Medical Education
515 North State Street, Suite 1801
Chicago, IL 60654

Dear Dr. Kopelow and the ACCME Board of Directors:

Thank you for giving the American College of Chest Physicians (ACCP) the opportunity to share our opinion on the recent call for comments. As you know, 2008 has been and continues to be a year of reflection, discussion, and change. The ACCP firmly believes that the ACCME needs to facilitate annual strategic meetings with necessary stakeholders who can assess and provide suggestions on how best to move forward with a new quality and outcomes-based CME initiative throughout the United States. Our response to each of the questions posed to the CME community appears below and reflects this concept with responses that impact the future of ACCME policies.

- Accredited providers must not receive communications from commercial interests announcing or prescribing any specific content that would be preferred, or sought-after, topic for commercially supported CME (eg, therapeutic area, product-line, pathophysiology) as such communication would be considered 'direct guidance on the content of the activity' and would result in Non-compliance with Standard 1 of the ACCME Standards for Commercial Support.**

We agree that specific content that reflects a specific treatment or product can be perceived as potentially influencing medical education content. However, we do not agree with completely eliminating all communication with industry about health issues that health-care providers experience daily. Company representatives hear these stories, some of which they cannot address immediately but we, as CME providers, can. If there is no communication between industry and CME providers, we lose access to potentially important information. This proposal as written should be reconsidered with a view toward permitting communication with industry and CME providers while protecting from undue influence related to a specific product line.

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2. **Receiving communications for commercial interests regarding a commercial interest's internal criteria for providing commercial support would also be considered the receipt of 'guidance, either nuanced or direct, on the content of the activity or on who should deliver that content.'**

We agree completely with this proposal. Having over 16,000 professional members who are content experts in the fields of pulmonary, critical care, and sleep medicine, the ACCP as a CME provider has access to the best teachers on a variety of content used in our certified/accredited CME activities that are also of interest to potential commercial supporters. Using these content experts accredited providers should not ask commercial supporters to define their internal criteria, especially for the approval of financial support, so that the request can be formulated and worded in such a manner to ensure approval of financial support by the potential supporter.

3. **The proposal is that the commercial support of continuing medical education end.**

We disagree with a blanket ban on all commercial support of CME. In 2006, 61% of CME revenue was derived from commercial sources, including the pharmaceutical and medical device industries. We recognize that the problem is not the amount of revenue that is generated, but rather that 20% of ACCME-accredited organizations are in noncompliance with one or more elements of the Standards for Commercial Support. We also recognize that the ACCME reviews are done retrospectively, and that it may take months or years for a CME provider to change a program to put it in compliance. These issues must be addressed, but a complete ban on commercial support should be implemented only when there is some empirical evidence that commercial support introduces bias or influences the content of certified/accredited medical education positively or negatively; obtaining that evidence would require some further study. ACCME recently agreed to this in its own response to the Macy Foundation report. Given that statement, we propose that ACCME act by facilitating a meeting of stakeholders from the CME provider community to discuss how commercial support is identified, used and managed in CME, as well as to develop and implement ways to assure compliance with ACCME's current Standards for Commercial Support. No such task force has been convened, other than the Consortium for Academic Continuing Medical Education (CACME) attempt to address these issues with a risk stratification tool that estimates the potential for commercial influence. Collecting this type of evidence would facilitate buy-in from CME providers without resorting to the elimination of all commercial support, and the resulting impact on certified and accredited CME. Prohibiting industry support for CME would probably lead to a reduction of accredited CME hours and a proportional increase in industry-sponsored promotional activities. We believe that industry will spend its dollars to reach physicians with or without CME funding, and that it is in the best interests of professional learners and patients that industry funds be channeled toward CME that is in compliance with ACCME criteria.

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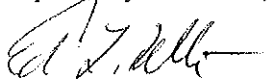
4. Persons paid to create, or present, promotional materials on behalf of commercial interests cannot control the content of accredited continuing medical education on that same content.

We disagree with a proposed policy that potentially eliminates content medical experts from participating in both promotional programs and accredited continuing medical education. Many times, the medical community seeks these key knowledge leaders' expertise. If this policy is implemented, physician learners will probably attend promotional activities to hear information from experts who no longer participate in CME programs. In our opinion, this policy would not solve the issues of potential bias by physician experts who present both in promotional and accredited medical education.

In conclusion, we emphasize the need to address the issues collaboratively as health care professionals and educators to ensure that educational programming is evidence-based, free of commercial influence and with effective and measurable outcomes. Imposing additional regulations in the absence of such study and development of reasonable guidelines will probably hurt the prospects of high-quality CME, especially now when providers are working to adapt to the updated criteria being implemented this year.

Thank you for your consideration. We would be happy to answer any additional questions that might develop from our responses, and look forward to future discussions on these important issues.

Respectfully submitted,



Ed Dellert, RN, MBA
Vice President, Educational Resources
American College of Chest Physicians

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