Lecturer conflicts of interest in medical school education: Raising the bar in BC

Declaring competing interest is common in medicine, so why is it so rare in medical schools?

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Evidence-based medicine is a significant component of early medical school curricula. At the University of British Columbia we are encouraged to critically evaluate evidence and search for bias in publications, presentations, and information presented by representatives of the pharmaceutical industry.

Indeed, a 2002 article in the *Annals of Internal Medicine* suggested that "…faculty, deans, and program directors should also promote sensitivity to potential biases by providing specific education to help their students, physician trainees, and medical fellows evaluate industry-provided information. For education and sensitivity training to be successful, however, faculty must act as positive role models. Chief residents and medical school faculty members should set ethical examples to students by conducting their relationships with industry in a highly principled manner and disclosing their own commercial ties."[1]

The faculty of medicine at the University of Toronto has been exemplary in its approach to lecturer conflicts of interest. In 2005, U of T instituted a policy stating "…before beginning a lecture or talk, speakers at all teaching events in clinical settings must provide statements about their potential conflicts of interest, including stock holdings, honoraria, consultancies and advisory board membership. The disclosure is intended to allow students to decide for themselves whether the information they receive in lectures is truly unbiased and evidence-based, says Dr Catharine Whiteside, the university's interim dean of medicine."[2]

Declaring competing interests is common in the medical community—the Canadian Medical Association, the British Columbia Medical Association, and the Royal College of Physicians and Surgeons of Canada have all released policy papers and guidelines addressing the relationship between physicians and the pharmaceutical industry.[3-6] In addition, the governing board for continuing medical education and the majority of medical journals enforce a disclosure policy. Nonetheless, more is required.

Although the most recent 2007 Canadian Medical Association guidelines state that "the [disclosure] principles in these guidelines apply to physicians-in-training as well as to practising physicians" and that "medical curricula should deal explicitly with the guidelines by including educational sessions on conflict of interest and physician-industry interactions," they do not expressly require lecturers to disclose industry ties.[3]

As well, the CME/CPD section of the guidelines is limited to "addressing primarily medical education initiatives designed for practicing physicians" and "educational events (such as noon-hour rounds and journal clubs), which are held as part of medical or residency training."[3] The CMA does not opine on the issue of lecturer conflicts of interest in medical school education, stating only that "those physicians with ties to industry have an obligation to disclose those ties in any situation where they could reasonably be perceived as having the potential to influence their judgment."[3] While a strict interpretation of this statement might encompass lecturing to medical students, ultimately it is left to physicians to determine whether their relationship with the pharmaceutical industry may affect their judgment.

Regrettably, the British Columbia Medical Association has gone no further than the CMA. In the 2007 paper *A Prescription for Quality*, the BCMA simply offers its "support [for] the CMA guidelines on appropriate relationships between physicians and the pharmaceutical industry and encourage[s] other health care providers to adopt similar guidelines."[5] Likewise, the Royal College of Physicians and Surgeons of Canada has only adopted the CMA Code of Ethics and the CMA Guidelines for Physicians in Interactions with Industry."[6]

Considering the aforementioned policies, or lack thereof, it is not surprising that medical schools have been left to develop their own guidelines concerning lecturer conflicts of interest.

Moreover, most medical faculties across Canada lack formal policies or guidelines regarding disclosure by lecturers of potential conflicts of interest notwithstanding the acknowledged importance of evidence-based medicine.

The education of physicians and other health care professionals must be conducted with the highest integrity, with scientific objectivity, and in the absence of bias. The medical profession is charged with the duty of

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optimizing the public's health by thinking critically and applying proven evidence-based principles. Accordingly, future physicians are trained to carry out this duty. Without disclosure in the training process, an excellent opportunity to allow students to exercise their developing critical thinking skills is lost. Furthermore, a disservice is done to the profession by inadvertently feeding an ever-growing public skepticism toward the influence of industry on physician decision-making.

Given the existing relationship between the pharmaceutical industry and so many practising clinicians and teachers, it would be unreasonable to suggest that those with ties be excluded from teaching positions. However, as students we have both the responsibility and power to put pressure on our respective faculties to institute, monitor, and enforce disclosure policies at the undergraduate level that are in line with the standards of continuing medical education and journal submission.

Competing interests

None declared.

References

1. Coyle S. Physician-Industry Relations. Part 2: Organizational Issues. Ann Intern Med 2002;136:403-406.
2. Catton M. Medical schools tackle conflict of interest. CMAJ 2005;173:1143.
3. Canadian Medical Association. CMA Code of Ethics. CMA Policy (Update 2007). http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD08-01.pdf (accessed 19 August 2008).
4. Canadian Medical Association. Guidelines for Physicians in Interactions with Industry. CMA Policy, 2007. http://policybase.cma.ca/dbtw-wpd%5CPolicypdf%5CPD08-01.pdf (accessed 19 August 2008).
5. British Columbia Medical Association. A Prescription for Quality. BCMA Policy Papers, 2007. www.bcma.org/public/patient_advocacy/APrescriptionforQuality.pdf (accessed 19 August 2008).
6. The Royal College of Physicians and Surgeons of Canada. Physicians and Industry—Conflicts of Interest. RCPSC Policy Statements and Guidelines, 2005. http://rcpsc.medical.org/publications/policy/physicians-industry_e.html (accessed 19 August 2008).

Dean's response

It is admirable that Wiens and Cota posit an opinion advocating for a strong system of instituting, monitoring, and enforcing disclosure policies that are "in line with the standards of continuing medical education and journal submission." In responding to the authors' stance it is important to highlight existing mechanisms dealing with disclosure under which faculty members affiliated with UBC's Faculty of Medicine operate.

First, the faculty is governed by the UBC Board of Governors, enacted by its comprehensive policies including Policy 97 (revised in 2005), which mandates a wide range of prescriptive behavior with regard to conflict of interest and conflict of commitment, as well as citing procedures to be followed by all faculty members engaged in research. Compliance to procedures began online in 2006, and I am pleased to report that the majority of our faculty have filed as required. Compliance is monitored by the Faculty of Medicine monthly, reported at least annually to faculty executive, and more frequently to department heads, with further action being taken if required. People have become more aware of the benefits of transparency and disclosing relevant potential conflict while giving lectures to medical students and trainees, as implicit in the policy. This awareness-building requires an ongoing educational process of our large distributed faculty.

Second, I point to the existence of the faculty's Continuing Medical Education/Continuing Professional Development Guidelines, which provide an expectation that conflicts of interest will be declared in these situations.

Third and finally, I note that both the American Association of Medical Colleges and the Association of Faculties of Medicine of Canada are also wrestling with conflict of interest policies related to the influence of industry on medical education, and we will continue to monitor those organizations' outcomes. Consequently, we are involved in a process to review existing policies (our own and others) to determine if additional measures may be required in declaring the conflict of interest as it applies more specifically to educating students to meet accreditation standards.

—Gavin Stuart, MD, Dean, UBC Faculty of Medicine