Conflicts of interest: a review of institutional policy in Australian medical schools

Eleanor Milligan and Allan W Cripps

To the Editor: Comparing Australian medical school policies regarding conflict of interest (COI) to their United States counterparts, Mason and Tattersall[1] conclude that within Australia there is "a need for improved self-regulation". The authors are applauded for highlighting this important aspect of medical education and organisational practice; however, the comparisons made fail to acknowledge a number of contextual differences that undermine the conclusions drawn.

First, significant cultural differences exist between Australia and the US with respect to historical market practices and commercial sponsorship within the tertiary education sector.[2] The persistent failure of self-regulation in the US recently culminated in the passing of the Physicians Payment Sunshine Provision, which now mandates transparent disclosure of all (> $10) payments, gifts and sponsorships, and imposes significant penalties for failure to report.[3] Arguably, it is this changing legislative landscape that has encouraged US medical schools to develop more robust COI policies, rather than a proactive commitment to manage COI.

Second, unlike in the US, most of Australia's 20 medical schools sit within publicly funded universities, where central policy regulation of COI prevails. Mason and Tattersall's[1] suggestion that each school have its own COI policy without reference to the overarching university's COI policy is flawed, particularly in a wider academic environment where industry sponsorship of education and commercialisation in research are increasingly encouraged as a desirable strategy to supplement falling levels of Commonwealth resourcing.

Third, despite the lack of policies in Australian medical schools, positive performances with respect to COI in the curriculum were noted,[1] demonstrating that lack of policy does not necessarily hinder appropriate curriculum content.

Finally, on becoming doctors, medical students are bound by their professional codes of practice, codes of ethics, organisational policies and state and federal legislation, which outline the obligation to act within the recognised standards of the profession.[4] While medical schools have a significant role to play in preparing future doctors to effectively recognise bias and appropriately manage COI,[5] their ability to enforce more rigorous standards than those that apply within the professional community at large is doubtful. The adequacy of current professional codes is a matter for further debate.

Medical schools exist within the wider context of the university, the community and the overarching political and legal landscape that governs their resourcing and practices. These factors must be taken into account when judging the actions of medical schools. To present Australian medical schools as lacking[1] on the basis of a decontextualised comparison with US schools may be overly simplistic.

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1 Mason PR, Tattersall MHN. Conflicts of interest: a review of institutional policy in Australian medical schools. *Med J Aust* 2011; 194: 121-125.
2 Association of American Medical Colleges. Industry funding of medical education. Report of an AAMC task force. Washington, DC: AAMC, 2008. http://www.ucsfcme.com/news/IndustryFundingMedicalEduation.pdf (accessed Jun 2011).
3 Policy and Medicine. Physician Payment Sunshine Provisions: Patient Protection Affordable Care Act passed the House. 2010 Mar 22. http://www.policymed.com/2010/03/physician-payment-sunshine-provisions-patient-protection-affordable-care-act.html (accessed Jun 2011).
4 Australian Medical Association. Position statement on doctors' relationships with industry — 2010. Canberra: AMA, 2010. http://ama.com.au/node/5421 (accessed Jun 2011).
5 Carmody DM, Mansfield PR. What do medical students think about pharmaceutical promotion? *Aust Med Student J* 2010; 1: 54-57. ❑

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In reply: The medical community in Australia regulates itself through various non-binding codes and guidelines, but these have not been shown to reduce industry influence on doctors or medical students. In contrast, the existence of institutional policies can limit the influence of industry, resulting in medical students and doctors who are less influenced by industry marketing.[1,2]

University conflict-of-interest (COI) policies must reflect the context in which they exist, but it is unlikely that a general university policy covering all faculties could address the specific challenges presented by medical student education. Policy development, while difficult, is possible, and the University of Melbourne is scheduled to complete a policy framework covering staff and students in health-related degrees this year.

Arguably, it was the failure of the medical profession in the United States to self-regulate that led to the legislative changes that stimulated the recent COI policy advances in US medical schools. This could also occur in Australia.

Despite the logistical difficulties of developing effective self-regulation within medical schools, there are increasing societal expectations that COI be dealt with effectively. If we ignore this sentiment, we risk the imposition of perhaps excessive and punitive legislation. Medical schools should embrace their influential position, and act now to demonstrate their leadership.

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1 Austad KEA, Kesselheim J. Medical students' exposure to and attitudes about the pharmaceutical industry: a systematic review. *PLoS Med* 2011; 8: e1001037.
2 Grande D, Frosch DL, Perkins AW, Kahn BE. Effect of exposure to small pharmaceutical promotional items on treatment preferences. *Arch Intern Med* 2009; 169: 887-893. ❑