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EDITORIALS

Leadership by example: saying no to health industry board membership

Prohibition is the best way to safeguard scientific and clinical integrity

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Although medicine came late to managing conflict of interest and promoting transparency, well after law, finance, and government, it now confronts many of the critical issues. Part of the impetus to change was externally driven, with state and federal legislation playing a key role in the United States. For example, US senator Charles Grassley led the initiative to compel drug and device companies to disclose all payments over $10 (£6.47; €8.95) to physicians and teaching hospitals, with the data accessible, name by name, on a public website.[1] But part of the impetus also came from within medicine. Several medical school deans believed that cozy ties between industry and faculty violated professional standards.[2] At the same time, medical researchers documented the extent and impact of these relations. In a linked paper (doi:10.1136/bmj.h4826) a study of this problem by Anderson and colleagues is an excellent case in point.[3]

The research into physician-industry ties helped alter attitudes and practices. Dozens of well designed articles refuted some physicians' self serving claims that "you can't buy me for a steak dinner," or for stays in lavish resorts, or sizeable payments to promote a new drug or device. As the researchers found, recipients of company gifts were much more likely to prescribe and use the company's products. Indeed, the company expended its funds to gain market share.[4 5]

Investigators also illuminated institutional conflicts of interest that had remained obscure. One study found that 60% of medical department chairs had financial relations with industry.[6] A commentary on these and other findings noted that academic health centres and industry have different missions. Academic medical institutions seek to expand knowledge through research and to deliver effective patient care; industry looks to enlarge markets and profits to benefit shareholders. Boston's not for profit health system, Partners, did limit the sums its administrators could receive from serving on a healthcare company board of directors, to $5000 a day. Even so, much more needs to be done to curb industry influence over academic institutions.[7]

The study by Anderson and colleagues strengthens the case for more stringent policies, by documenting the extent of these ties. In total, 279 academically affiliated directors, including chief executive officers, presidents, trustees, provosts, deans, and department chairs from 85 non-profit academic institutions received in aggregate $55m in compensation for serving on for profit health industry boards; on average they received annual payments of $193 000 and, in addition, stock options. The sums are unsettling—hardly a steak dinner—but effective institutional guidelines have yet to be agreed upon or widely implemented.

The authors provide only limited guidance by way of solutions. Accusations from a small cadre of disgruntled physicians notwithstanding, no one seeks to demonize industry. Academy-company cooperation is necessary for medical progress. But how do we safeguard scientific and clinical integrity, ensuring that it is knowledge and not market share that shapes research and clinical practice? How do we keep the playing field level when industry dispenses hundreds of thousands of dollars to academic leaders?

Anderson and colleagues outline a range of policy choices: compel leaders to disclose and make public the sums they receive, have institutions review disclosures case by case, limit the payments leaders can receive, have leaders consult to companies without compensation, and prohibit the relationship itself. The authors do not advocate a specific solution, so how should we proceed?

Some policies are too weak to warrant much discussion. Disclosure, given the data presented here, already exists; company annual reports and filings provide the information, but this does not inhibit relationships. Institutional case by case determinations are possible But what should be the operating standards and how can institutional leaders be prevented from putting pressure on their subordinates? Payments could be limited, but to how much? And why is $5000 a day acceptable but not $50 000? Even if leaders served on boards without taking payment, there are other more indirect ways that both companies and institutions could find to do each other favours.

Although it may seem radical, excluding leaders from directorships is the only credible policy. Critics insist directorships promote cooperation and progress; but obviously many ways exist for sharing knowledge without joining a board.

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By analogy, it is often claimed that Food and Drug Administration advisory committees must be allowed to appoint members with conflicts of interest because they are the most knowledgeable. But surely their insights could be obtained without appointing them to a committee—for example, letting them testify without giving them committee status or votes.

The gains, however, are clear. For one, education by example: medical students, fellows, and assistant professors would have a powerful example to emulate. Yes, share information with industry as appropriate, but do not take payment, travel, and the rest. For another, independence would make apparent that academic medical institutions stand apart, guided by professional principles, autonomous in theory and practice. In this domain as in many others, integrity must take precedence over individuals' compensation.

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