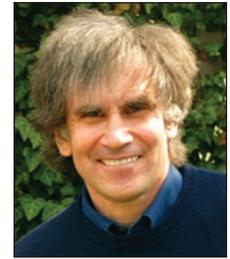


Intramural conflicts of interest warrant scrutiny, too

Matthew Movsesian



Matthew Movsesian

Medical school faculty receiving remunerations from industry have financial incentives for promoting the products of the companies paying them. It's no surprise, then, that medical schools require disclosure and management of such relationships. Yet, despite their greater prevalence and more profound influence, the financial incentives offered by medical schools have gone largely unnoticed. A consistent standard for disclosure and management should be applied to both intramural and extramural financial relationships.

The belief that consulting fees and other remunerations from industry can adversely affect the educational activities of medical school faculty has led many such teaching institutions to require the disclosure and management of faculty members' relationships with private companies. Curiously, people have taken little, if any, notice of the financial incentives provided by medical schools themselves. Yet these intramural incentives are far more prevalent than those from industry and have an even greater ability to influence the activities of medical school faculty.

Part of the problem may be a failure to appreciate that US medical schools have evolved into big businesses that derive most of their income by providing healthcare services and securing extramural research grants. In 2009, for example, 53% of medical school revenues came from clinical services and 29% from extramural grants. By comparison, less than 4% came from tuition (<https://www.aamc.org/data/finance/2009tables/>). The primacy that these academic medical centers assign to their revenue-generating activities in their labs and clinics is hardly surprising. Like their nonacademic counterparts, academic medical centers vie for clinical market share through direct-to-consumer advertising. To increase referrals, they offer free continuing medical education programs that boost the visibility of their more profitable services to community providers. Physicians with MBA degrees are becoming increasingly common at academic medical centers, and executives at these teaching institutions are paid industry-level salaries. Schools regularly patent the discoveries by faculty members that have the potential to develop into profitable products, and they strive to partner with industry by licensing out the related intellectual property.

There is no reason to think that faculty members who can be swayed by payments from industry are immune to the pressures of institutional incentives.

It's worth noting that medical school faculty members perceive that their revenue-generating activities are of paramount importance in the eyes of academic leadership. In a recent survey of faculty at US medical schools, 51% of respondents agreed that "the administration is only interested in me for the revenue I generate"¹; a less extreme statement might have elicited more widespread concurrence.

Emphasis on revenue generation by faculty is evident in the incentive plans that typically compensate clinicians in proportion to the billable services they provide. And researchers understand that their salaries for time spent on research must be paid, sometimes in full, from extramural grants. However, the influence that this dependence on clinical and research revenue can have upon faculty members is usually overlooked. For example, a recent study of clinical guidelines from the American Heart Association and American College of Cardiology noted that 56% of the authors of the guidelines received money or owned stock in companies that might benefit from the recommendations²; the accompanying

opinion suggested banning most of these relationships to eliminate conflicts of interest³. But the faculty who serve on such guideline committees—arrhythmia specialists who write guidelines for pacemaker implantation, for example—are likely to be compensated by their universities in relation to the number of procedures performed. This gives them an economic incentive to favor these procedures in their recommendations, regardless of their individual financial relationships with industry.

I witnessed a rare exception to the inattention given to intramural incentives within medical schools at the 2010 annual scientific meeting of the Heart Failure Society of America. At the conference, a speaker comparing the merits of endomyocardial biopsy and gene-expression profiling to screen for heart transplant rejection disclosed—in an introductory slide usually dedicated to industry funding—that the institution where he works and teaches does more than 800 endomyocardial biopsies a year. Each of these biopsies generates a professional fee for the cardiologist performing the procedure (\$700 at the speaker's institution) and a technical fee for the catheterization laboratory (almost \$1,900), in addition to other associated payments. Although the speaker concluded that each procedure was suitable under certain circumstances, the prospect

of forfeiting this income offered a strong financial incentive for him to promote reliance on endomyocardial biopsy rather than gene-expression profiling, which requires only a venipuncture.

The incentives medical schools offer to encourage revenue generation are fundamentally similar to those affecting faculty members lecturing on a product while being paid by its manufacturer, and the breadth of their influence is greater. Why these incentives have escaped the scrutiny that

has been drawn to relationships with industry is unclear, but there is no reason to think that faculty members who can be swayed by payments from industry are immune to the pressures of institutional incentives. A consistent standard should be applied to both. If disclosure and management of relationships with industry are desirable, comparable expectations should apply to all potentially influential sources and mechanisms of compensation, including those from faculty members' own institutions.

Matthew Movsesian is a professor of internal medicine and pharmacology at the University of Utah School of Medicine, Salt Lake City, Utah, USA.

1. Pololi, L., Ash, A. & Krupat, E. <https://www.aamc.org/download/154216/data/your_career_is_more_than_your_specialty_-_246.pdf> (2010).
2. Mendelson, T.B., Meltzer, M., Campbell, E.G., Caplan, A.L. & Kirkpatrick, J.N.. *Arch. Intern. Med.* **171**, 577–584 (2011).
3. Nissen, S.E. *Arch. Intern. Med.* **171**, 584–585 (2011).

