

# GRAVITAS

m. (feminine gravitatis) a quality of substance or depth  
m. (feminine gravitatis) caractère de ce qui a de l'importance



## AFMC

The Association of Faculties of Medicine of Canada  
L'Association des facultés de médecine du Canada



## Réflexions *Nick Busing, Président-directeur général*

Les facultés de médecine canadiennes sont d'importantes institutions et leurs missions tripartites de formation médicale, de recherche et de soins cliniques comportent des responsabilités sociales inhérentes envers ceux que nous desservons. Les facultés de médecine doivent assurer que nos effectifs médicaux actuels et futurs sont bien préparés pour répondre aux besoins diversifiés et en constante évolution de la population canadienne. Elles doivent voir à ce que nos chercheurs en sciences biomédicales et de la santé produisent des résultats de recherche de calibre mondial et avant-gardistes. Elles doivent veiller à ce que les Canadiens reçoivent des soins cliniques fondés sur des données probantes, efficaces et fournis de manière appropriée.

En plus de ces responsabilités spécifiques, nos facultés voient aussi à ce que les étudiants, les résidents, les professeurs et les chercheurs fassent preuve du plus haut niveau de professionnalisme qui soit, y compris dans leurs rapports avec l'industrie.

Le sujet des conflits d'intérêts revêt une importance grandissante pour l'AFMC. C'est en partie attribuable à de récentes causes aux États-Unis, dans lesquelles la justice a poursuivi des membres du milieu médical pour ne pas avoir divulgué des conflits d'intérêts ou des partis-pris réels ou perçus dans leurs travaux. Dans les poursuites qui ont retenu l'attention, on peut mentionner les cas de chercheurs en médecine qui effectuaient des études sur des médicaments fabriqués par des entreprises dont ils étaient actionnaires ou avec lesquelles ils entretenaient des relations contractuelles, de professeurs qui prononçaient des conférences

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President & Chief Executive Officer/

Président-directeur général

Nick Busing (nbusing@afmc.ca)

VP, Government Relations and External Affairs/

Vice-président, Relations gouvernementales  
et affaires externes

Irving Gold (igold@afmc.ca)

VP, Research and Analysis CAPER-ORIS/

Vice-président, Recherche et analyse CAPER-ORI

Steve Slade (sslade@afmc.ca)

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VP, Research and Analysis CAPER-ORIS/ Vice-président,

Recherche et analyse CAPER-ORI

Steve Slade (sslade@afmc.ca)

Editor/Éditeur: Irving Gold

Managing Editor/Coordonnatrice: Natalie Russ

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## Réflexions *Nick Busing, Président-directeur général*

concernant des interventions médicales au moyen de diapositives et de textes produits entièrement par les promoteurs de ces procédures ou encore de médecins ayant reçu des cadeaux ou une rémunération de l'industrie sans les avoir déclarés.

L'AFMC s'intéresse de près à ce sujet pour une autre raison bien plus importante encore. Les Canadiens accordent une grande confiance à leurs médecins et à leurs chercheurs en sciences de la santé. Il faut voir à ce que cette confiance ne soit pas trahie, dans les faits ou en apparence, et ce, au moyen de politiques appropriées et efficaces en matière de conflits d'intérêts. C'est tout simplement la bonne chose à faire. Les Canadiens doivent être confiants que les soins qu'ils reçoivent et que la recherche en sciences biomédicales et de la santé que nous effectuons au pays, sur laquelle repose les soins fondés sur des données probantes qu'ils reçoivent, s'appuient non seulement sur les meilleures données factuelles possibles et sur l'expérience de leurs médecins et qu'ils ne soient nullement influencés par des intérêts autres que des résultats optimaux sur le plan de la santé.

L'AFMC et nos facultés membres ne croient pas qu'il soit nécessaire de rompre tous les liens avec l'industrie; en réalité, ce serait purement absurde. L'industrie apporte d'importantes contributions au système de santé canadien. Sans elle, de multiples traitements et dispositifs médicaux qui améliorent directement la vie des Canadiens n'existeraient tout simplement pas. Elle exerce un rôle essentiel.

Nous devons assurer, en tant d'institutions ayant pour principal devoir de servir les intérêts des Canadiens, la mise en place de mécanismes appropriés pour démontrer que toutes nos interactions avec l'industrie sont au-dessus de tout reproche. De fait, ce faisant, nous agissons dans l'intérêt supérieur de toutes les parties concernées. La contribution d'Irving Gold au présent numéro de *Gravitas* comporte un résumé de ce que font l'AFMC et nos facultés membres dans cet important domaine. J'espère que vous réfléchirez comme nous à ces questions et que vous travaillerez avec nous pour veiller à ce que nous soyons des chefs de file dans l'élaboration de politiques sur les conflits d'intérêts qui mettent notre secteur à l'abri des reproches et à ce qui nous puissions continuer à travailler de manière productive et transparente avec nos partenaires de l'industrie. 🍁

## L'AFISS rénove son site Web et amorce la deuxième étape du projet.

L'initiative portant sur l'agrément de la formation interprofessionnelle en sciences de la santé (AFISS), financée par Santé Canada, met à contribution un partenariat national regroupant huit organisations responsables de l'agrément de la formation préalable à l'obtention d'un permis d'exercice dans six professions de la santé au Canada : la physiothérapie, l'ergothérapie, la pharmacie, le travail social, les sciences infirmières et la médecine.

Le projet sur l'AFISS en est à la deuxième étape de ses travaux qui prend appui sur les principes communs servant à guider l'élaboration de normes d'agrément de la formation interprofessionnelle (FIP) en sciences de la santé qui sont le fruit de la première étape. Les membres du projet sur l'AFISS travaillent à intégrer des normes de FIP dans l'agrément des programmes de formation dans ces six disciplines participantes des sciences sociales et de la santé. Pour plus de renseignements, visitez [www.aiphe.ca](http://www.aiphe.ca) ou communiquez avec le secrétariat du projet de l'AFMC à [mshahin@afmc.ca](mailto:mshahin@afmc.ca)

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Gravitas is the official quarterly newsletter of The Association of Faculties of Medicine of Canada. Opinions expressed in this bulletin do not necessarily reflect the views of the Association. Contributions to Gravitas in either English or French are welcomed. Advertisements are also accepted. Gravitas is sent free of charge to members of the Association.

Gravitas est le bulletin trimestriel officiel de l'Association des facultés de médecine du Canada. Les opinions exprimées dans ce bulletin ne sont pas nécessairement celles de l'Association. Les contributions à cette publication sont les bienvenues et peuvent être rédigées en français ou en anglais. Les annonces publicitaires sont également acceptées.

## Reflections *Nick Busing, President & CEO*


Canada's faculties of medicine are important institutions, and their tripartite missions of medical education, research, and clinical care carry with them important social responsibilities to those we serve. Faculties of medicine must ensure that our current and future physician workforce is well equipped to serve the diverse and ever-changing healthcare needs of the Canadian population, that our health and biomedical researchers produce world-class, cutting-edge research, and that the clinical care Canadians receive is evidence-based, safe, effective, and delivered in an appropriate fashion.

In addition to these specific responsibilities, our faculties must also ensure that students, residents, clinicians, educators, and researchers in our faculties exhibit the highest levels of professional conduct, including with respect to their relationships with industry.

The topic of conflict of interest (COI) has become increasingly important for the AFMC. In part, this is because of recent developments in the United States where lawmakers have taken members of the medical establishment to task for non-disclosure of conflicts of interest and real or perceived bias in the work they do. Scenarios which have received attention include medical researchers conducting drug trials when they are shareholders or have contracts with the firms producing the drugs under study, faculty members being paid to give talks regarding medical interventions with slides and presentations being wholly prepared by the vendors of the interventions, and physicians receiving undisclosed gifts and remuneration from industry.

The topic is an important one for AFMC for another, more important reason. Canadians place a great deal of trust in their physicians and health researchers. Ensuring that this trust is not violated, either in fact or appearance, through appropriate and effective conflict of interest policies is simply the right thing to do. Canadians must be confident that the care they receive, and the health and biomedical research we conduct in this country, which forms the basis for the evidence-based care they receive, is based on the best-available evidence and the experience of their physicians and is in no way influenced in any way by interests other than optimal health outcomes.

AFMC and our member faculties do not believe that we need to eliminate all linkages with industry; indeed, that would be sheer folly. Industry is an important contributor to Canada's healthcare system – without them, countless treatments and medical devices that directly improve the lives of Canadians would simply not exist. The role they play is critical.

We must ensure that as institutions with a primary duty to serve the interests of Canadians, we have appropriate mechanisms to demonstrate that we are above reproach in all of our interactions with industry. In fact, doing this serves the best interests of all parties involved. Irving Gold's contribution to this edition of *Gravitas* includes a summary of what AFMC and our member faculties are doing in this important area. I hope you will reflect on these issues as we are, and work with us to ensure we are leaders in the creation of COI policies that protect our sector from reproach and ensure that we can continue to work productively and transparently with our industry partners. 

## The Deanery



*Gavin Stuart pursued a fellowship in gynaecologic oncology at Wayne State University in Detroit. He then moved to the Tom Baker Cancer Centre in Calgary where he was the first Director of Gynaecology. After a short period as Head of the Department of Obstetrics and Gynaecology, he was appointed as Professor and Head, Department of Oncology and Director of the Tom Baker Cancer Centre.*

*As Dean since 2003, Dr. Stuart has worked with a large team, government and a large number of partners to enhance health research in British Columbia and oversee the implementation of a provincially-based faculty of medicine across four campuses. He is past Chair of the Board of Directors of the Association of Faculties of Medicine of Canada, and was made an Honorary Alumnus of UBC Faculty of Medicine in 2009.*

*Dr. Stuart has been active in leadership roles on many national and U.S. committees on medical education, in health human resource planning and in evidence-based guideline development. In 2010, he was elected to the Canadian Academy of Health Sciences.*

## Conflicts of Interest and Conflicts of Commitment

*Gavin C.E. Stuart, Dean, Faculty of Medicine, Vice Provost Health, University of British Columbia*


Universities in general and faculties of medicine specifically are responsible for the advancement and dissemination of knowledge. However, the expectations of society, regulatory agencies, government and other bodies require that the advancement and dissemination of knowledge is conducted in an ethical and rigorous manner that is done with integrity and free of conflict of interest. The required social accountability of a faculty of medicine is such that it is not adequate to commit to these principles but that the principles must be actively demonstrated and managed with transparency.

Faculty and staff within a university are obliged to disclose any real or perceived conflict of interest. This means that in any circumstance in which an individual or group may be seen to benefit from an action that the mechanism of this benefit be disclosed and understood. This process varies amongst institutions but normally it would take the form of an annual signed disclosure to the appropriate authority within the university environment. It must be emphasized that conflict of interest may be real or perceived and have equal and/or different results.

The second consideration to note is that a conflict of interest is not inherently bad. Some conflicts are unavoidable and can arise from the very nature of one's role and/or engagement. Sometimes these may be permissible if appropriately managed and others will be prohibited. Regrettably, disclosure of a conflict of interest is viewed with a pejorative connotation that limits transparency for some individuals and in some settings.

Thirdly, it is not enough to disclose a real or potential conflict alone without a management plan. This management plan may be to acknowledge that the conflict is present and mitigate the impact. Alternatively, it may be to remove the individual(s) from the setting and seek alternate activities. However, an active management plan for a real or perceived conflict is the most effective manner of addressing this. Inherent within this management plan must be a level of individual confidentiality but is restricted only to those individuals or agencies that require access to such information.

More recently, in addition to conflict of interest, universities have focused on a conflict of commitment. Particularly within a faculty of medicine where the activities of faculty members are diverse and varied health institutions and academic institutions wish to be assured that the resources that they are providing in the form of either compensation, space and/or time is aligned with the activities of the individual faculty and staff members. This again is a fine balance between supporting the academic freedom of an individual, faculty member and ensuring accountability.

This issue of *Gravitas* is committed to explore the complex issues of conflicts of interest and conflict of commitment. Any institutional policy and procedures regarding this matter must be based on sound principles and be proudly supported in order to be effective and constructive. Universities have a responsibility to teach the strategies of how to avoid and manage conflict of interest to its trainees thereby ensuring that these principles are passed onto subsequent generations of professionals. 



Tom Freeman is Chair of the Department of Family Medicine at the Schulich School of Medicine & Dentistry at The University of Western Ontario and Chief of Family Medicine at the London Health Sciences Centre and St. Joseph's Healthcare London. He obtained his MD from The University of Western Ontario, in 1976 and after completing a residency in family medicine at Dalhousie University in Halifax, conducted a full service family practice in Woodstock, Ontario. In 1989, he undertook a full-time academic position with the Department of Family Medicine and obtained a Masters of Clinical Science degree. He is co-author with Dr. Ian McWhinney of the third edition of *Textbook of Family Medicine* and with Stewart et al, of *Patient Centered Medicine: Transforming the Clinical Method*. He continues to practice at the Byron Family Medicine Centre.

## Conflict of Interest and Canadian Medical Schools - An Overview

Tom Freeman, Chair, Department of Family Medicine, Schulich School of Medicine & Dentistry, The University of Western Ontario

Though it may not be receiving the publicity that is occurring in the United States, the issue of the relationship between medical schools and industry (principally pharmaceuticals and medical devices) has become a top drawer item for faculties of medicine in Canada as well. High profile cases in leading American medical schools, in which some faculty have received considerably higher remuneration from industry than from their parent institution, has caused some to question the objectivity that is at the core of the academic enterprise. This has spawned U.S. Senate probes that have garnered a great deal of publicity in that country. Though there have, as yet, been no similar cases in Canada, attendees at a recent AFMC National Dialogue on Conflict of Interest were cautioned that it is 'only a matter of time'.

In 2008, the Association of American Medical Colleges endorsed a report from the Macy Foundation entitled *Industry Funding of Medical Education* that contained 15 wide-ranging recommendations. Subsequently, in Canada, AFMC added its endorsement to this report and all of the faculties of medicine in Canada have been reviewing and updating their policies in this area.

Great benefits in new therapeutics have accrued from the relationship between medical schools and industry and it is vitally important that this collaboration continue and be strengthened. For both parties, maintaining public trust is key. Though medical schools and industry share a common goal of advancing medical knowledge and treatment they differ, in important ways, in their fiduciary responsibilities and this difference creates the potential for conflicts of interest. Industry is responsible to shareholders for a return on investment, whereas medical schools are responsible to act in the best interests of patients, students and the research enterprise. Further, there is robust evidence from the psychosocial literature and brain imaging studies that gifts of any kind influence decision making and that we are literally 'hard wired' to respond in a reciprocal manner to everything from simple gifts, to sponsorship and personal relationships. Given this context, conflicts of interest are inevitably going to arise, and it is, therefore, important that institutions put in place policies that identify and manage them.

The central goal of conflict of interest policies is to protect the integrity of professional judgement, preserve the public trust and provide faculty with guidance about what is or is not permitted in the complex relationship with industry. The AFMC continues to support faculties of medicine in Canada as they continue to move forward in this important activity. ❀

### AIPHE revamps website and starts second phase of project

The Accreditation of Interprofessional Health Education (AIPHE) initiative, funded by Health Canada, is a national collaborative of eight organizations that accredit pre-licensure education for six Canadian health professions: physical therapy, occupational therapy, pharmacy, social work, nursing and medicine.

AIPHE is in its second phase of work which builds on the shared principles for accreditation of interprofessional health education (IPE) standards that were developed in the first phase. AIPHE members are working towards the integration of IPE standards into the accreditation programs of the six participating health and social care programs. For information on AIPHE's activities, please visit [www.aiphe.ca](http://www.aiphe.ca) or contact the AFMC project secretariat: [mshahin@afmc.ca](mailto:mshahin@afmc.ca)



Russell Williams became President of Rx&D in March 2004. Prior to joining Rx&D, Mr. Williams had a successful career in provincial politics and community service. For fifteen years, he represented the Montreal riding of Nelligan in the National Assembly of Quebec. During his career as Liberal MNA, he led numerous public policy debates on important and complex issues, such as the role of government in research and development (R&D), compensation for victims of contaminated blood, linguistic policy, access to services for the disabled, and pre-hospital emergency services. He is well known for his dedication and perseverance as an advocate for individual rights and government services focused on the needs of its citizens. He continues active volunteer involvement in palliative care.

1 <http://www.nice.org.uk/page.aspx?o=343446>

2 [http://www.cachecanada.org/1/images/stories/Conferences/CACHE\\_2010/CACHE\\_Collab\\_5pg.pdf](http://www.cachecanada.org/1/images/stories/Conferences/CACHE_2010/CACHE_Collab_5pg.pdf)

3 [http://www.councilofthefederation.ca/pdfs/Prem\\_Working\\_to\\_Sustain\\_Economic\\_Recovery.pdf](http://www.councilofthefederation.ca/pdfs/Prem_Working_to_Sustain_Economic_Recovery.pdf)

*“A principled relationship between private and public sectors has the potential to bridge the innovation gap and better utilize Canada’s richest natural resource: our people.”*

## Principled Partnerships - A Uniquely Canadian Approach to Innovation

*Russell Williams, President, Canada’s Research-Based Pharmaceutical Companies (Rx&D)*

The innovative pharmaceutical industry in Canada has a long history of successful and mutually beneficial collaboration with the broad community represented by the AFMC. We have worked together to support the AFMC’s mission, “to ensure the health of Canadians by promoting and supporting excellence in health education and research.”

Our industry and its members believe strongly that reasonable and practical conflict of interest (COI) guidelines can strengthen our partnership and also inspire public and stakeholder confidence.

To begin with, the definition of COI is often a matter of debate. In our view, it occurs when public duties cannot be reconciled with usually private or personal interests, but we also must recognize that a conflict can also exist between professionals or the public sector.

The key is to establish solid, sensible and workable guidelines to avoid conflicts as much as possible and deal with concerns fairly when they are raised. There will be fewer conflicts when everyone knows the rules.

Often, the discussions about conflict of interest apply only to the private sector. But potential conflicts can also exist in the public sector as well. This fact has been recognized in guidelines developed, for example by the National Institute for Health and Clinical Excellence in the UK.<sup>1</sup>

The COI guidelines must also be reasonable and balanced. We live in an increasingly complex world where talented people are in great demand in their specialized field. If Canada is to fully embrace innovation in health care, we need the expertise of the best people with divergent backgrounds and perspectives to get the best possible results. Limiting the participation of a qualified scientist or a health care professional on the basis of some connection with an industry does not in our view, serve the public interest.


Transparency and trust are two other important components. For the past two decades, Rx&D member companies and all their employees have been governed by a Code of Ethical Practices to ensure all interactions with health care professionals meet the highest standards of ethics.

Finally, the COI guidelines must be created and administered in a spirit of true partnership. This means that all parties involved should have a seat at the table early in the process of creating reasonable and practical COI guidelines.

The benefits of collaboration were recognized by participants at a Stakeholder Summit held by the Canadian Association of Continuing Health Education. “A collaborative approach among CHE (Continuing Health Education) stakeholders is the desired strategy for the development of a sustainable system of high quality, ethical CHE in Canada.”<sup>2</sup>

A principled relationship between private and public sectors has the potential to bridge the innovation gap and better utilize Canada’s richest natural resource: our people.

At the annual meeting of The Council of the Federation held in Winnipeg in August, Provincial Premiers called for “greater collaboration between industry and academia,”<sup>3</sup> to foster a culture of innovation in Canada.

In this spirit, I believe that we can work together to develop a “Made in Canada” collaborative approach that will improve the quality of care and the health of our citizens. 



## Guidelines for the Relationship between Medical Education and Industry: More questions than answers

*Dianne Delva, Associate Dean, Undergraduate Medical Education, Dalhousie University*

*Lynette Reid, Assistant Professor, Department of Bioethics, Dalhousie University*

*Dianne Delva is the Associate Dean, Undergraduate Medical Education at Dalhousie University. She is a family physician with a long interest in medical education and faculty development. In her most recent role, she has tackled the challenge of curriculum renewal, the expansion of the program to a satellite campus in New Brunswick and innovation in interprofessional education.*

*Lynette Reid is an assistant professor in the Department of Bioethics at Dalhousie University. She provides ethics education across the continuum of medical education, and has been intimately involved in Dalhousie's curriculum renewal process. Her primary responsibilities are for program development and evaluation, as well as coordinating the delivery of ethics education by our faculty. She completed a doctorate in philosophy at the University of Illinois at Urbana-Champaign, specializing in philosophy of language, ethics, and ancient philosophy. She completed postdoctoral work both in philosophy of language and in bioethics at Toronto and Dalhousie.*

In the clinical setting, students may come into contact with pharmaceutical representatives at meetings or during sessions designed for physicians and residents. We have clear policies on the relationship with industry in this situation, whether forbidding or requiring “chaperones”. Do we prepare our students adequately to critically appraise these interactions? Ethics helps students reason about conflict of interest, and evidence-based medicine gives students practice in critical appraisal. What is the hidden curriculum we are teaching our students when they learn about relationships with industry and then are taken to a pharmaceutically-sponsored dinner?

And what of more subtle interactions? Students are provided with gifts from MD management and often meet representatives from banks when they are starting medical school. Students receive generous loans so that they will bring business to the lending institutions. Does the medical school have a role in examining these practices? What of educational resources offered or sponsored by business?

The student Pharmfree campaign got a boost when a Harvard lecturer mentioned a brand-name drug and students uncovered his industry ties. Now that disclosure is the norm. Should it begin in first year? Does disclosure work as a strategy for managing conflict of interest?

And finally, what of the well-meaning professor fashioning a memorable education event? A screening test is not covered by provincial plans, but the pharmaceutical representative can provide it, to drive home the wisdom of prevention. Because students attend class fasting, food is provided. Do ethics and evidence-based practice inform this, or do students have to make the connections? Another professor taps industry funds to give honoraria to patients visiting class: does this enrich the curriculum, or invite concerns? What should be disclosed? What prompts the pharmaceutical representative to contribute to these educational events?

Physicians depend on the advances in the pharmaceutical industry to assist their patients. The profession seeks to distinguish between fruitful collaboration and inappropriate influence. Students appreciate gifts and support from financial institutions. The role of the undergraduate curriculum committee is to educate students and faculty of the possible influence that industry may have on their practice and ensure that the hidden curriculum does not undermine our efforts. 🌐



### Nomination de professeur Pierre Cossette en tant que doyen de la Faculté de médecine et des sciences de la santé à l'Université de Sherbrooke

Le professeur Pierre Cossette, directeur du département de médecine, sera le prochain doyen de la Faculté de médecine et des sciences de la santé (FMSS). Il entrera officiellement en fonction le 26 septembre 2010.

Pierre Cossette a obtenu son doctorat en médecine à l'Université de Montréal en 1991. Il a fait ses études médicales postdoctorales en médecine interne à l'Université de Sherbrooke, de 1991 à 1995, et a obtenu une maîtrise en épidémiologie et biostatistiques de l'Université McGill en 1999. Il est devenu, en

1997, professeur au Département de médecine, Service de médecine interne, puis, en 1998, directeur du programme de médecine interne – tronc commun, avant d'assumer, en 2004, la direction du Département de médecine, poste qu'il occupe depuis.

Pierre Cossette est fort impliqué, tant à la Faculté qu'au Centre hospitalier universitaire de Sherbrooke (CHUS). Il a su établir un leadership reconnu autant par les membres de son Département que par les instances administratives, médicales et universitaires. Il a d'ailleurs reçu le Prix du Leadership médical de l'Association québécoise des établissements de santé et de services sociaux (AQESSS) et le grand prix d'excellence du conseil d'administration du CHUS.

**L'AFMC félicite le Dr Cossette de son nomination récemment et lui accueille au Conseil d'administration de l'AFMC.**



## TANSTAAFL – Conflict of Interest Guidelines and Postgraduate Medical Education in Canada

*David McKnight, Associate Dean, Equity & Professionalism, Faculty of Medicine, University of Toronto*  
*Salvatore M. Spadafora, Vice Dean Postgraduate Medical Education, University of Toronto*

*David McKnight is Associate Dean, Equity & Professionalism in the Faculty of Medicine at the University of Toronto. After graduating from medical school, he trained in anesthesiology there and has practised at St. Michael's Hospital since 1980. He is a past program director of the anesthesia residency program at U of T.*

*He has a long standing interest in ethics and completed the Master of Health Sciences in Bioethics at the Joint Centre for Bioethics at the University of Toronto in 2006. He has chaired the ethics committees of both the Canadian Anesthesiologists' Society and the Royal College of Physicians and Surgeons of Canada (RCPSC). He also completed terms as chair of the Accreditation Committee and as a member of Council at the RCPSC.*

*Salvatore (Sal) Spadafora is the Vice Dean, Postgraduate Medical Education at the University of Toronto and an Anesthesiologist at Mt. Sinai Hospital in Toronto. He previously served as associate dean of postgraduate medical education, at the Schulich School of Medicine & Dentistry at the University of Western Ontario and an anesthesiologist at the London Health Sciences Centre and St. Joseph's Health Centre in London.*

*A graduate of the University of Toronto, Faculty of Medicine, Dr. Spadafora has distinguished himself as a leader in medical education. He also completed his Masters in Health Professions Education at the University of Illinois, Department of Medical Education. A past program director for the University of Western Ontario's anesthesia and family medicine residency programs; and, nationally as a member of important leadership committees of the Canadian Anesthesiologists' Society and the Royal College of Physicians and Surgeons of Canada.*

Robert Anson Heinlein (1907–1988) was often called “the dean of science fiction writers”. He coined the term TANSTAAFL for “There ain’t no such thing as a free lunch” to communicate the idea that it is impossible to get something for nothing. Although one usually associates the “free lunch” with sponsored Continuing Medical Education (CME) events for practising physicians, the world of Postgraduate Medical Education (PGME) in Canada is not immune. From muffins at morning rounds to pizza at lunch, the pretence of the “free lunch” is ubiquitous in our training programs. Think of the “free” text books, the sponsored journal clubs, and, in a few residencies, whole academic programs funded by industry.

Does it matter? After all, who has not enjoyed a “free lunch”? Are learners (and teachers) worse for it? Many think not, but keep in mind the obligation and influence that comes with any gift, even as trivial as sandwiches and coffee. We should also acknowledge the sense of entitlement that develops until this is the expected norm — recall the indignation when the food does not appear at rounds or when journal club is in a hospital seminar room rather than an upscale restaurant.

What will be key as medical schools adopt Conflict of Interest (COI) guidelines is accountability. How is corporate money spent, reported, tracked and accounted for? Accountability in PGME should be three-fold: internal (to faculty/department/division); to the donor; and to the public. We do not believe that there is general wrong-doing in the handling of such financial support to PGME, but there are examples of donations made to individuals instead of programs, of funds that are not recorded or reported, and of the accumulation of reserve funds (“war chests”) that are rarely the intention of the donor.

In order to ensure transparency and accountability, standards must be developed that set out requirements for a centralized deposit to programs or departments rather than individuals. Proper financial reporting mechanisms, as well as reporting to the donor, will ensure transparency in an otherwise unregulated process. Compliance with these simple processes will create a consistent and expected standard for all residency programs.

Conflict of Interest guidelines in PGME need not seek to eliminate industry support, but the application of reasonable standards will ensure accountability for all stakeholders. Declaration is not always sufficient management of COI, but it is always the first step.

TANSTAAFL is an acknowledgment that in reality we cannot get “something for nothing”. There is always a cost or expectation in return. We are obliged as medical educators, physicians, and citizens to identify the “hidden costs” and to improve how we deal with them. 🚫



“*AFMC will continue to serve as a resource to our faculties of medicine as they navigate this challenging but important road.*”

## The First National AFMC Dialogue on Conflict of Interest

*Irving Gold, Vice President, Government Relations and External Affairs*

At its fall 2008 meeting, the Board of Directors of the Association of Faculties of Medicine of Canada (AFMC) formally endorsed the principles set out in the Association of American Medical Colleges' (AAMC) report titled *Industry Funding of Medical Education*. The report was the result of a 14-month effort by an AAMC task force, established in 2006, to examine the benefits and pitfalls associated with industry funding of medical education, and to develop principles, recommendations, and guidelines to help medical schools and teaching hospitals better manage their relationships with industry.

Among the recommendations contained in the report was a call to prohibit drug industry gifts and services to physicians, faculty, residents, and students, eliminate faculty participation in speakers' bureaus, and to curtail the involvement of industry in continuing medical education activities.

Speaking in reference to the report, AAMC President and CEO Darrell G. Kirch, M.D., said that “Interactions between industry and academic medicine are vital to public health. But they must be principled partnerships effectively managed to sustain public trust in both partners' commitment to patient welfare and the improvement of health care. The recommendations outlined in this report provide essential guidance for how medical schools and teaching hospitals can achieve this important goal.”

Canada's medical education leadership clearly agreed. Dr. Harold Cook, Chair of the AFMC Board of Directors at the time, said “Our academic relationships with industry are important and complex. The AAMC report outlines a series of principles which, when implemented, provide more transparent and coherent policies for industry engagement.” Dr. Nick Busing, President and CEO of AFMC further remarked that “there is no question that industry plays an important role in supporting all aspects of our healthcare system, including medical education. This endorsement ensures that this support does not lead to real or perceived conflicts of interest, and sets the stage for more fruitful interactions.”

On August 24th and 25th 2010, the AFMC held a national 2-day meeting on the topic of conflict of interest which brought together representatives from faculties across the country. The purpose of the meeting was to explore where Canadian faculties of medicine are in terms of their own COI policies and to begin a process of collaboration and discussion among our faculties and with our many partners.

In addition to representatives from AFMC and our faculties, the meeting was also attended by Dr. Claudia Adkison from Emory University. Dr. Adkison has been a thought leader in the United States in the area of COI and has been working with the AFMC and its members since the endorsement of the AAMC report occurred.


*Continued on page 10*

The meeting was an interesting one. After hearing from Dr. Adkison about Emory's experience developing and implementing COI policies, participants had focused discussions around issues such as COI and research, clinical care and medical education, COI and continuing medical education, speakers' bureaus, COI disclosure and reporting, and enforcement of codes.

Each faculty also had a chance to report on their COI policies, their processes of revision (if applicable) and where they were planning to go in the future.

AFMC will continue to serve as a resource to our faculties of medicine as they navigate this challenging but important road. More specifically, AFMC will hold further meetings on the topic as necessary. The next meeting, to be held in the spring of 2011, will bring our faculties together with other stakeholders such as the Canadian Medical Association, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada as well as our industry partners such as Rx&D.

AFMC will also create a space on the Canadian Healthcare Education Commons (CHEC) for our faculties which will serve as a repository of documents and resources for our faculties including relevant reports published in and outside of Canada, teaching resources pertaining to COI, as well as codes and policies from across the country. The space will also have interactive functions such as collaborative workspaces and a discussion board.

As always, we invite your feedback. If you have documents that you think would be relevant for inclusion in our repository, or if you want any information, please do not hesitate to get in contact with me at: [igold@afmc.ca](mailto:igold@afmc.ca) 



## Conflict of Interest and the “Culture of Entitlement”

*Penny Davis, Assistant Dean, Continuing Professional Learning, College of Medicine, University of Saskatchewan*

*Co-Chair, AFMC Standing Committee on Continuing Professional Development*

There is a culture of “entitlement” of support from industry and foundations which has developed among physicians. It does not appear to be limited to any age or ‘time-in-practice’ cohort, but embraces almost all physicians, despite rising recognition of the presence of conflict of interest in our learning, teaching and prescribing processes.

Before we can challenge this culture we need to ask where conflict of interest management is taught in our medical schools. Is it through the formal curriculum where we teach what we believe students and residents need to know, the informal curriculum where we teach what we are and what we do, or in the hidden curriculum where by ignoring issues we give them credibility?

In preparation for a workshop on conflict of interest I walked from the hospital car park to the teaching hospital through an industry sponsored elevated walkway, past an industry sponsored lecture theatre and MRI unit, and into the College of Medicine where I looked at my own office. There students and residents see me work, surrounded by several pieces of equipment from pens to pregnancy calculators decorated with pharmaceutical company logos. None of these areas was a formal part of the school of medicine building, but all help to prepare the student for the acceptable presence of financing from industry sources.

Think of the education sessions for practising physicians (and any students on their service) where an excellent speaker is imported by industry, with a modest lunch. Outstanding speakers

“ *To develop a culture of conflict of interest risk management there must be a comprehensive approach with firm policy guidelines, adequate faculty education, and explicit identification and discussion of the implications of risk situations throughout the formal medical school curriculum.* ”

## The Future of Medical Education in Canada (FMEC) Implementation – New Online Communities to Help Mobilize Action



AFMC encourages all medical educators to play an active role in the FMEC implementation. Ten new online communities have been created on the Canadian Healthcare Education Commons (CHEC) to help mobilize action and share resources pertaining to each FMEC recommendation. To join an FMEC community, go to [www.afmc.ca/fmec/](http://www.afmc.ca/fmec/) to find the FMEC recommendations that interest you. The FMEC communities will go live on **Monday, October 25**.

CHEC is a web-based platform designed to encourage collaboration in all areas relating to medical education. In addition to an online repository, CHEC is dedicated to communities, offering online spaces for people with common interests to talk, share resources, collaborate and move projects and ideas forward.

## Mise en œuvre du projet sur l'Avenir de l'éducation médicale au Canada (AEMC) – Nouvelles communautés virtuelles pour aider les intervenants à se mobiliser pour agir

L'AFMC encourage tous les éducateurs en médecine à jouer un rôle actif dans la mise en œuvre du projet sur l'Avenir de l'éducation médicale au Canada. Au total, dix nouvelles communautés virtuelles ont été créées dans le cadre de la Collaboration pour l'éducation en santé au Canada (CESC) afin d'aider les intervenants à se mobiliser pour agir et à partager des ressources relatives à chacune des recommandations découlant du projet sur l'AEMC. Pour rejoindre les rangs d'une communauté de l'AEMC, rendez-vous sur [www.afmc.ca/fmec/](http://www.afmc.ca/fmec/) afin de trouver les recommandations sur l'AEMC qui vous intéressent. Le lancement des communautés de l'AEMC aura lieu le **lundi 25 octobre**.

La CESC est une plate-forme internet conçue pour favoriser la collaboration dans tous les secteurs liés à l'éducation médicale. En plus d'offrir un référentiel virtuel, la CESC est axée sur les communautés, offrant, aux personnes partageant un même intérêt, des espaces en ligne leur permettant de parler, d'échanger des ressources, de collaborer et de faire avancer projets et idées.

can always be found to discuss the latest antihypertensive or diabetes drug, but how often is a similarly brilliant speaker imported to discuss the benefits of counseling, lifestyle change, weight loss and regular exercise, the benefit of which is equally significant for the patient. In these circumstances who is in charge of our curriculum?


We insist on disclosure of conflict of interest by our own and visiting faculty, but should declaration of multiple sponsorships or support for scholarly work set our minds and consciences at rest? Only if we have ensured that our students and residents have acquired the skills to understand their implications.

In an environment where pharmaceutical companies invest more in sales initiatives than on research and development, who carries the load of this investment? Is it industry with the ability to deduct expenses from income, physicians who attend or teach at industry sponsored education sessions, or reliance on industry support to pad inadequate budgets?

Unfortunately, the answer must be that *patients* carry the load through the cost of pharmaceuticals. Subsidized education reinforces the importance of prescribing as the core of physician responsibility versus the hard work of inducing lifestyle change. Historically, this sprang from the miracle of disease modifying drugs such as antibiotics which gave physicians the power to intervene rather than observe and set the scene for the medical profession's love affair with pharmaceuticals and the people who make them. We in Canada pride ourselves on teaching 'patient centered medicine', but in this area we do not practise what we preach. Somewhere teaching of conflict of interest management crept from the informal into the embedded curriculum where acceptance becomes endorsement.

There is serious underfunding in both medical education and treatment facilities. In the treatment sector there is the expectation that the general population will play a part in providing enhanced facilities for patients, through hospital auxiliaries and foundations. As we move to distributed education our students learn from many preceptors in many sponsored facilities. Without a strong overall policy these preceptors have no guidance, and responses to these issues, where responses exist, cross the spectrum from total immersion in to total insulation from the commercial environment.

To develop a culture of conflict of interest risk management there must be a comprehensive approach with firm policy guidelines, adequate faculty education, and explicit identification and discussion of the implications of risk situations throughout the formal medical school curriculum.

Students and practising physicians must acquire and use critical review skills, and in addition to prescribing skills develop patient centered management skills including costs and lifestyle modification, but most of all acceptance of our own responsibility to obtain and finance our lifelong learning. 

*Penny Davis is currently Assistant Dean of Continuing Professional Learning in the College of Medicine at the University of Saskatchewan. She received her undergraduate training from the University of Birmingham in England and she graduated in medicine 1971. She received her postgraduate diplomas in paediatrics and obstetrics and gynaecology in 1972-3. Her academic appointments also include clinical assistant professor for the Department of Academic Family Medicine; and clinical lecturer for the Department of Obstetrics, Gynecology and Reproductive Sciences in the College of Medicine at the University of Saskatchewan.*



*Jeff Blackmer completed his medical training at the University of Western Ontario and his residency training in Physical Medicine and Rehabilitation at the University of Saskatchewan. Following residency, he completed a Master's degree in medical ethics through the University of Toronto at the Joint Centre for Bioethics.*

*He has previously served as the interim Director of Ethics for the World Medical Association in Geneva. He contributes to local, national and international efforts in medical ethics through activities such as chairing the Ethics Committee at The Ottawa Hospital, serving as an expert advisor in medical ethics to the World Health Organization in Geneva, and chairing various ethics working groups of the World Medical Association. He has published and lectured extensively both nationally and internationally on various issues in medical ethics, and has authored numerous national and global policies on medical ethics and professionalism. He has been an invited Visiting Professor in medical ethics at several Canadian hospitals and medical schools and also at institutions such as the University of Notre Dame and the United States National Naval Medical Centre.*

## The Canadian Medical Association's Perspective on Conflict of Interest

*Jeff Blackmer, Executive Director, Office of Ethics, Professionalism and International Affairs, Canadian Medical Association*

The Canadian Medical Association (CMA) serves as the representative voice for the physicians of Canada. Our Code of Ethics, which has been in existence since 1868 and is referenced by every other major medical body in Canada, addresses the complex issue of conflict of interest as follows:

### Responsibilities to the Patient

#### General Responsibilities


11. Recognize and disclose conflicts of interest that arise in the course of your professional duties and activities, and resolve them in the best interest of patients.
12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.

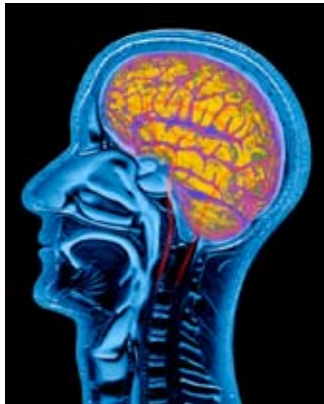
The CMA Code of Ethics is considered to be a “hybrid code”; it is more than a “10 Commandments”-type document, but also more concise than an ethics textbook. Because of this, the CMA develops policies on specific topics in ethics and professionalism that may be of importance to its membership.

In 2007, the CMA Committee on Ethics considered the issue of conflict of interest and developed background material and resources on the topic, but ultimately decided that the subject matter was too complex and broad for the CMA to have a specific and focused policy in this area. The most important and salient points that physicians need to know on a day-to-day basis are captured by the Code of Ethics: that conflicts must be recognized, disclosed and resolved; and that patients must be informed about such conflicts.

The CMA policy “Guidelines for Physicians in Interactions with Industry” elaborates on the issue of conflicts as they pertain specifically to physician-industry interactions. This policy states:

4. Physicians should resolve any conflict of interest between themselves and their patients resulting from interactions with industry in favour of their patients. In particular, they must avoid any self-interest in their prescribing and referral practices.
6. 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.

By and large, the information contained in these two CMA policies, when properly interpreted and applied, is of assistance to our members in addressing and working to resolve the majority of their conflicts. When more specific information is required, we often refer our members to the policy on conflict of interest of the World Medical Association, which was developed by the CMA and is available at: <http://www.wma.net/en/30publications/10policies/i3/index.html> 



a place of mind



FACULTY OF MEDICINE



## CALL FOR NOMINATIONS

# The Margolese National Brain and Heart Disorders Prizes

The University of British Columbia's inaugural *Margolese National Brain and Heart Disorders Prizes*, each with a value of C\$50,000, will be awarded in 2011.

The *Margolese National Brain Disorders Prize* will be awarded annually to a Canadian who has made outstanding contributions to the treatment, amelioration, or cure of **brain disorders**. The *Margolese National Heart Disorders Prize* will be awarded annually to a Canadian who has made outstanding contributions to the treatment, amelioration, or cure of **heart disorders**. The Prizes are awarded with the expectation that the Prize recipients will continue to demonstrate excellence in their field of work.

**Deadline for nominations:** October 1, 2010, midnight – Pacific Time

**For further information:**

[www.med.ubc.ca/research/dfo/faculty/margolese.htm](http://www.med.ubc.ca/research/dfo/faculty/margolese.htm)

## SAVE THE DATE

May 7th-11th, 2011

Canadian Conference on Medical Education  
(Toronto Ontario)

It is my pleasure to invite you to attend the 2011 *Canadian Conference on Medical Education* being held May 7-11th, 2011 in Toronto, Ontario. This conference is the largest gathering (over 1100 in 2010) of medical educators in Canada and offers a unique opportunity to network with colleagues from across the country, to hear new ideas, to acquire new knowledge and to share your expertise. It is also an opportunity for our partner organizations to hold meetings and honour many of our colleagues with awards.

Our University of Toronto colleagues are hosting the conference in May 2011 at the Sheraton Hotel in the heart of downtown Toronto.

The theme of this year's conference is Scholarship in Medical Education

Plenary session titles are as follows:

- Valuing Scholarship
- Research in Medical Education
- Scholarship of Social Accountability

\*Please note that we will once again be using the interactive key pads.

The 2011 Scientific Program Committee (SPC) includes: Dr. Carol Ann Courneya, Chair of SPC (representing CAME), Dr. Joan Sargeant, Chair of Selection Committee (representing CAME), Dr. Geneviève Moineau, Past Chair of SPC (representing AFMC), Dr. Sarita Verma (representing AFMC), Dr. Barbara Stubbs (representing CFPC), Dr. Allyn Walsh (representing CFPC), and Dr. Tim Wood (Representing MCC), Dr. Sydnee Smee (representing MCC), Dr. Jason Frank (representing RCPSC) and Ms. Leslie Flynn (representing RCPSC) with support from Ms. Susan Maskill (Conference Secretariat, AFMC).

This unique collaborative effort continues to pay dividends both in improving the quality of the conference as well as expanding the international scope of the conference; 2010 brought even more international colleagues to St. John's.

Response to our 2010 conference was extremely positive. Delegates commented on the wide range of medical education topics covered, as well as the amazing networking opportunities. The 2010 theme will live on in the form of the second "White Coat Warm Art" exhibit as well as a Poetry Prose Contest for 2011!

Please stay tuned for more information on the 2011 Canadian Conference on Medical Education.

Approximate timeline:

### September 2010

- Call for Proposals (Workshops, Oral and Poster Presentations) goes out on September 7th, 2010
- Accommodation and Venue information available online

### January 2011

- Online Registration begins
- Preliminary Program available online

For more details on the conference please visit the conference website at [www.mededconference.ca](http://www.mededconference.ca)

Please mark May 7th – 11th, 2011 for this conference in your calendars now. I look forward to seeing you in Toronto.

Sincerely,

Carol-Ann Courneya PhD, Chair, 2011 Scientific Program Committee

## DATE À RETENIR

Du 7 au 11 mai 2011

Conférence canadienne sur l'éducation médicale  
(Toronto Ontario)

J'ai le plaisir de vous inviter à assister à la *Conférence canadienne de 2011 sur l'éducation médicale* qui se tiendra du 7 au 11 mai 2011, à Toronto, en Ontario. Cette Conférence est la plus importante réunion (plus de 1 100 participants en 2010) d'éducateurs du domaine médical au Canada. Il s'agit d'une occasion unique d'échanger avec vos collègues de l'ensemble du pays, de vous familiariser avec de nouveaux concepts, d'acquérir de nouvelles connaissances et de partager avec autrui vos compétences spécialisées. C'est aussi, pour nos organisations partenaires, l'occasion rêvée d'animer des réunions et de reconnaître le travail de plusieurs de nos collègues en leur décernant des prix.

Nos collègues de l'University of Toronto sont les hôtes de la Conférence qui se tiendra en mai 2011 à l'Hôtel Sheraton situé en plein cœur de Toronto.

Cette année, la Conférence a pour thème La mission professorale en éducation médicale.

Voici les titres des séances plénières :

- Valoriser la mission professorale
- La recherche en éducation médicale
- La mission professorale relative à la responsabilité sociale

\*Veuillez noter que cette année encore, nous utiliserons les claviers interactifs.

Le Comité du programme scientifique (CPS) de la Conférence de 2011 se compose des personnes suivantes : la Dre Carol Ann Courneya, présidente du CPS (représentant l'ACÉM), la Dre Joan Sargeant, présidente du Comité de sélection (représentant l'ACÉM), la Dre Geneviève Moineau, présidente sortante du CPS (représentant l'AFMC), la Dre Sarita Verma (représentant l'AFMC), la Dre Barbara Stubbs (représentant le CMFC), la Dre Allyn Walsh (représentant le CMFC), le Dr Tim Wood (représentant le CMC), la Dre Sydnee Smee (représentant le CMC), le Dr Jason Frank (représentant le CRMCC) ainsi que Mme Leslie Flynn (représentant le CRMCC) avec le concours de Mme Susan Maskill (Secrétariat de la Conférence, AFMC).

Cet effort de collaboration unique continue à rapporter, tant en rehaussant la qualité de la Conférence qu'en élargissant la portée internationale de celle-ci. En 2010, nous avons accueilli à St. John's un nombre accru de collègues de l'étranger.

La réaction suscitée par notre Conférence de 2010 a été extrêmement positive. Les délégués ont commenté sur la vaste gamme de sujets d'éducation médicale couverts ainsi que sur les incroyables occasions de réseautage. Le thème de 2010 se perpétuera grâce à la deuxième exposition « Artistes en blouse blanche » ainsi qu'à un concours de poésie et de prose prévu pour 2011!

Demeurez à l'écoute pour obtenir plus de renseignements sur la Conférence canadienne de 2011 sur l'éducation médicale.

Échéancier approximatif :

### Septembre 2010

- Lancement de l'appel d'offres (ateliers, présentations orales et par affiches) le 7 septembre 2010
- Mise en ligne des renseignements afférents à l'hébergement et au lieu de présentation

### Janvier 2011

- Début de l'inscription en ligne
- Mise en ligne du programme préliminaire

Pour de plus amples renseignements sur la Conférence, prière de consulter le site Web à l'adresse suivante : [www.mededconference.ca](http://www.mededconference.ca)

Notez dès maintenant dans votre agenda la date de cette Conférence (du 7 au 11 mai 2011). Au plaisir de vous voir à Toronto.

Sincères salutations,

Carol-Ann Courneya, PhD Présidente, Comité du programme scientifique de 2011