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EDITORIAL

Conflict of interest management before, during, and after the 2005 International Consensus Conference on cardiopulmonary resuscitation and emergency cardiovascular care science with treatment recommendations

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To preserve the public trust and integrity of the International Liaison Committee on Resuscitation (ILCOR) evidence evaluation process, in 2004 ILCOR established a conflict of interest (COI) policy[1] to manage any real or potential conflicts of interest in an open and effective manner. This editorial explains the ILCOR and American Heart Association (AHA) COI policies and their application throughout the 2005 evidence evaluation process. ILCOR and the AHA also invite readers' questions and feedback on this process.

The value of the ILCOR evidence evaluation process depends on rigorous expert review of published science. Therefore, it is essential that any potential professional conflict of interest be fully disclosed and managed effectively during the planning and conduct of the evidence evaluation process, especially when issues arise. Because many of the world's most qualified scientific experts may have professional relationships that could pose a real or perceived conflict of interest, it is not always possible to avoid all involvement by such persons. It is necessary, however, to limit and manage their involvement in areas of potential conflict, especially to minimise their influence over consensus statements or recommendations in such areas. ILCOR COI procedures applied to all ILCOR delegates, 2005 Consensus Conference participants, observers, worksheet experts, worksheet authors, editors of the ILCOR 2005 CPR Consensus document (published in this supplement), and all others working on ILCOR projects.

As host of the 2005 Consensus Conference, the AHA also required every participant to complete an AHA COI disclosure questionnaire and to comply with all AHA COI policies. The purpose of the AHA COI policies and procedures[2] is to protect the integrity of the AHA's decision-making processes and the *2005 AHA Guidelines for CPR and ECC*, as well as to protect the public's trust in the AHA and AHA volunteers and staff.

Summary of COI procedures

Each participant in the 2005 evidence evaluation process completed and submitted both an ILCOR and an AHA COI disclosure form before attending

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the 2005 Consensus Conference.[3] Late registrants were required to complete the COI disclosure forms when they registered on-site. AHA staff reviewed the forms and ensured that completed versions of both forms were submitted by each conference participant and worksheet author. ILCOR task force cochairs (e.g. cochairs of the Basic Life Support, Advanced Life Support, and Pediatric Resuscitation Task Forces) reviewed the forms for potential conflicts of interest. COI-related questions or concerns were submitted to the ILCOR COI cochairs (John Billi and David Zideman) for resolution. Corrective actions included reassigning topics or moderator roles to persons without a significant conflict of interest or limiting persons with a significant conflict of interest to the role of reviewer of the evidence. In the latter instance, panellists with no conflict of interest made any final judgments based on the evidence and drafted any consensus statements or summaries. The AHA and ILCOR have retained all disclosure forms together with written records of actions taken.

Each evidence evaluation worksheet (see the editorial on evidence evaluation in this supplement) included a section for the author to disclose potential conflicts of interest. Worksheets without a completed COI section were not accepted. The COI information submitted for each worksheet was cross-referenced for accuracy and consistency with the COI information on file with the AHA and ILCOR.

At the start of the 2005 Consensus Conference each participant was given a printed COI disclosure booklet listing each attendee's name and institution and the basic details of any declared professional relationship that could pose a potential conflict of interest (see COI listing at doi: 10.1016/j.resuscitation.2005.11.001 or www.elsevier.com/locate/resuscitation). Each participant was assigned a participant number. COI information for each participant was listed numerically in the COI booklet, which was updated daily with additional COI disclosure information from late registrants.

Throughout the 2005 Consensus Conference, continuous COI disclosure for all speakers (scheduled or unscheduled) was provided without interruption or delay in the proceedings. Every speaker, whether moderator, presenter, panelist, or someone making comments from the floor, was required to state his or her name and participant number. A slide listing the speaker's institution and COI disclosure information was projected on a designated screen for the duration of the speaker's comments. This provided conference participants with immediate and continuous information on any relationships the speaker had that could pose a COI issue. Participant numbers enabled participants to immediately crosscheck disclosures in the conference COI disclosure booklet. Late registrants were required to make verbal disclosures until their information could be posted on a slide.

All moderated sessions, questions from the audience, comments, and statements were audiorecorded for future reference. All speakers stated their participant numbers each time they spoke, making the task of identifying recorded speakers easier and assessment of the impact of potential conflicts of interest possible.

A COI monitor was assigned to each session to ensure that policies were followed and to record any irregularities. The monitors' reports were reviewed and retained as part of the AHA COI documentation file. Conference participants were repeatedly reminded to raise COI issues with COI monitors, moderators, or cochairs. Participants were also given the number of a confidential COI phone ''hotline'' to enable them to report issues anonymously if they did not wish to make their comments in person. The methods through which participants could raise potential COI issues were displayed on the screens in the plenary sessions several times each day.

During the conference any new COI problems or questions that could not be resolved by the session moderators were referred to the ILCOR COI cochairs for rapid resolution. If an issue was deemed sufficiently challenging, it was referred to the Ad Hoc COI Committee (see Results). The Ad Hoc COI Committee was composed of the 2005 Consensus Conference coordinator (William Montgomery), conference cochairs (Vinay Nadkarni and Jerry Nolan), and COI cochairs (John Billi and David Zideman). Moderators were instructed to stop discussion immediately if they believed that the session should not continue until a specific COI issue was resolved and to go on to the next presentation to enable the COI cochairs time to resolve the issue. After resolution the panel was permitted to resume the earlier presentation and discussion.

Results of COI Policy implementation

All 380 participants in the 2005 Consensus Conference completed COI disclosure forms, most before the conference. Staff added information from late registrants to daily updates of the COI disclosure booklet and slides. Although a few reminders were needed on the first day of the conference, all conference participants quickly adopted the habit of giving their name and participant number whenever they spoke.

COI cochairs investigated and recommended resolution for 8 concerns before the conference and 12 concerns during the conference. One COI issue required that the Ad Hoc COI Committee convene. On another occasion a discussion was stopped when a floor debate appeared centered on a detail of interest to device manufacturers and the debaters had potential or perceived links with the manufacturers as disclosed on the COI slides. In this instance the COI monitor and session moderators conferred, then asked all participants to send any further written comments to the Task Force for consideration. The comments included the authors' participant numbers so that their COI disclosures could be considered when their input was weighed. Throughout the poster sessions a COI policy/rationale poster was displayed and attended by one of the COI cochairs. This stimulated much discussion, raising awareness of the importance of good COI management.

No anonymous calls were received on the COI hotline. Twelve participants voluntarily revised their COI disclosure forms once they observed the comprehensive level of disclosure of their peers or were reminded of relationships that might pose a potential conflict. In two instances one participant was aware of a potentially conflicting, undisclosed relationship of another participant. In both instances a COI cochair investigated the issue, and the disclosure forms, booklet, and slides were updated.

A participant survey conducted after the 2005 Consensus Conference indicated almost uniform support for the COI disclosure method. The common responses were ''very effective'' and ''nonintrusive''. A few participants indicated that the disclosure was too continuous, but several others thought it did not go far enough. Ninety percent of the 120 respondents ''strongly agreed'' or ''agreed'' that speakers' relationships with commercial entities were clearly disclosed during the 2005 Consensus Conference. One unintended benefit of the simultaneous projection of the COI slide was that the audience always knew who was speaking, something that can be difficult to discern in a large meeting with floor microphones.

Readers are welcome to provide feedback on any aspect of the ILCOR or AHA COI policies and implementation. Please contact any of the authors at www.C2005.org.

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