

Protecting Academic Freedom

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ABSTRACT

Five senior academic researchers and administrators, under the auspices of the Canadian Association of University Teachers (CAUT), **formed** a task force that reviewed threats to academic freedom for clinical faculty working in Canadian universities and their affiliated teaching hospitals and research institutes and made recommendations. The task force identified increasingly hierarchical and corporate structures in health care as a threat to academic freedom and developed four recommendations. Faculty mission statements, guidelines, and affiliation agreements should include strong language supporting academic freedom. Faculty appointment and income should be protected against threats arising from exercise of academic freedom. The resolution of alleged misconduct should proceed rapidly on the basis of adjudication consistent with principles of natural justice and procedural fairness. Finally, clinical faculty need strong representational organizations that will provide effective assistance when academic freedom is threatened. These policy changes are necessary to prevent further erosion of academic freedom in Canadian academic medicine.

THE PROBLEM

Excellence in academic medicine, as in all fields of research and innovation, depends on a work environment characterized by intellectual curiosity, relentless critical inquiry, and a passion to advance scientific knowledge and improve clinical practice. Such an environment depends on academic freedom - the right of academic staff to teach, study and publish regardless of prevailing opinion, and of prescribed doctrine or institutional preferences, and the freedom to express critical opinion about workplace institutions and broad public issues.

Academic health sciences professionals, unlike the faculty colleagues in all other disciplines, typically do not have real protection for their academic freedom – as occasionally becomes visible in cases such as the internationally publicized story of Nancy Olivieri.^{1,2,3} Olivieri, in an industry-funded clinical trial conducted at the University of Toronto, generated findings suggesting that a drug intended to reduce iron overload in children with thalassemia ~~was not effective~~ [lost its effectiveness over time](#) and caused important toxicity. The trial's sponsor, Apotex, terminated the trial and threatened Olivieri with legal action if she disclosed the risks to her patients or anyone else. The University of Toronto failed to provide her with effective assistance, and the Hospital for Sick Children subjected her to harassment that escalated into actions that almost ended her career.¹

In a second widely publicized case, David Healy, a prominent Welsh psychiatrist, had accepted a leadership position at a psychiatric hospital affiliated with the University of

Toronto.^{4,5} After he gave a lecture in which he suggested that SSRIs – a family of antidepressant drugs – may be associated with increased risk of suicide, the hospital withdrew the job offer that Healy had already accepted. Since that time, taking a stance consistent with Healy's concerns, the U.S. Food and Drug Administration has issued a Public Health Advisory warning physicians, their patients, and families of the possibility of suicidal thoughts and actions with ten anti-depressants.⁶ The British Medicines Healthcare Products Regulatory Agency earlier had taken a similar stance regarding the dangers of SSRIs, particularly in children.⁷ Both Olivieri and Healy negotiated favorable settlements with the University of Toronto with the assistance of the Canadian Association of University Teachers (CAUT), a national organization representing academic staff at universities across Canada, and the University of Toronto Faculty Association (UTFA).

Unfortunately, other highly publicized examples are ongoing. At Dalhousie University, Dr. Gabrielle Horne and Dr. Michael Goodyear have had their hospital privileges varied (Goodyear's were subsequently revoked) and their careers severely compromised, if not destroyed. Despite statutory expectations that the matter would be reviewed within a month, the Capital District Health Authority (CDHA) took more than three years to prepare a report for its Board in Horne's case and still has not prepared its report in Goodyear's. In neither case have there been any charges substantiated, or resolution to the processes. The District Medical Staff Association commissioned an independent panel to review the allegations against Horne and found "no documentation to support the

allegations” and called for full reinstatement of her privileges. CDHA ignored these recommendations.⁸

The Olivieri, Healy, Horne and Goodyear stories, and similar cases in the United States^{9,10} illustrate the fragility of academic freedom for clinical faculty – a term we are using to refer to health sciences professionals, generally with MD or PhD degrees, who hold simultaneous appointments at both a university and a teaching hospital or other health care institution.

Clinical faculty face greater vulnerability to attacks on academic freedom than do nonclinical academic faculty for several reasons. First, clinical faculty must defend their rights on two fronts – the university, where academic freedom is given some recognition, and in the health care institution, which typically is far more hierarchical, and without strong traditions of protecting dissent and criticism. Second, unlike non-clinical faculty who typically derive their income from the university payroll, clinical faculty secure income from a variety of sources, including remuneration for clinical work. Thus, interference with income stream is a potential form of retaliation against clinical faculty for exercising academic freedom rights. Finally, a majority of clinical faculty in Canada are excluded by law, choice, or tradition from membership in the bargaining units of university faculty associations and, with respect to their relationship to health care institutions, are typically one of the few groups with no collective agreement to protect their rights.

THE MAGNITUDE OF THE PROBLEM

In this article we will suggest that major initiatives to guarantee the academic freedom of clinical faculty are necessary, as they are in all other fields of inquiry, to foster creative and innovative work. Over the past five years, CAUT has received over 20 ~~several~~ ~~dozen~~ complaints that suggest ~~that~~ attacks on the academic freedom of clinical faculty – whether in relation to the findings of their research, criticism of institutions, or differences of views with colleagues – are widespread. These attacks take place in universities and their associated research institutions, and sometimes in associated hospitals. The details of these complaints must remain confidential because of the potential jeopardy to the individual precisely because institutional protection for academic freedom is lacking.

Testimonials from leaders in academic medicine indicate that physicians who present formal complaints to CAUT represent a small proportion of those who have suffered harassment, curtailment of academic advancement, or job loss. Indeed, members of this committee have experienced colleagues denied academic advancement, and having university and hospital appointments threatened, as a result of their political, scientific or clinical viewpoints; their unwillingness to provide authorship on publications to undeserving colleagues; and their criticisms of institutional leadership. The intense personal anguish of the situation, a desire to avoid life becoming mired in the consequences of harassment, and a fear of worse consequences if complaints become public, are all strong disincentives to lodging formal complaints.

FINDING A SOLUTION

Troubled by the absence of protection for academic freedom of clinical faculty, CAUT convened a group of five senior academic clinical faculty, each with many years of research and administrative experience, to develop recommendations for addressing the problem. The group's mandate was to develop a set of recommendations that, if implemented, would lead to greater protection of clinical faculty's academic freedom. The task force met six times over two years, and developed recommendations that cover four key areas.

Strengthen the Rules Governing Academic Freedom for Clinical Faculty

The rules, both formal and informal, that govern the working lives of clinical faculty are set out in a broad collection of written instruments – mission statements, guidelines, policies, affiliation agreements and employment contracts – that establish the norms of university and health care institution life. Few such documents contain strong statements regarding academic freedom. An unequivocal commitment to academic freedom in these documents is important both to establish a legal and policy basis for faculty rights and to foster a culture of institutional respect for academic freedom. University and health care institutional mission statements, institutional policy statements, university-hospital affiliation agreements, funding plans, collective agreements and employment contracts must include strong, explicit statements unequivocally declaring academic freedom to be a core principle of academic medicine. That said, we are well aware of the limitations of these sorts of statements. Ironically, the University of Toronto, site of both the Olivieri

and Healy cases, has a mission statement that includes exemplary language regarding academic freedom which .

Ensure Security of Appointment and Security of Income for Clinical Faculty

To be effective, declarations of academic freedom rights require additional protections. Security of employment, including security of income, is key for exercise of academic freedom. Measures to protect security of employment of clinical faculty should include eligibility for tenure with the university. Security in respect to relationships with health care institutions and funding mechanisms is more complex. To provide such security there must be established rules; the appointment or privileges to practice must be of renewable limited term and terminable only for cause. The rules should specifically include protection for academic freedom such that the exercise of academic freedom cannot be a justification for non-renewal, variance or termination. The task force recognized that, whatever the rules and safeguards, those in power can break the rules. Indeed, in a number of instances, hospital and university administrations have, with apparent impunity, ignored existing rules. Thus, the final two areas of recommendation are perhaps the most important.

Ensure Access to Natural Justice for Clinical Faculty

In conflicts involving the rights of individuals, fair and effective dispute resolution includes a set of principles known as natural justice. The principles include the right to be informed of allegations, the right to a hearing in a timely manner, the right to disclosure of evidence, the right to legal representation, the right to present evidence and to

challenge the evidence presented by others, the right to know the reasons for any decision rendered and, most important of all, the right to an independent, unbiased judge or arbitrator. When the institution's leadership judges a faculty member who has crossed swords with a pharmaceutical company on which the institution is financially dependent, the judge is neither independent nor unbiased. When senior colleagues judge a faculty member known for adversely criticizing the institution's leadership, the judges are subject to conflict of interest. When powerful, senior faculty members level charges against junior colleagues, judges who rub shoulders with the accusers cannot be objective. Universities, health care institutions and clinical funding plans must ensure that clinical faculty have access to dispute resolution procedures characterized by natural justice and procedural fairness, including access to independent external arbitration for resolution.

Strengthen the Representational Organizations of Clinical Faculty

The courts represent the pinnacle of natural justice within our society. We are all aware, however, that lack of resources may seriously compromise the likelihood of obtaining justice, while resources to recruit an outstanding legal team greatly increase the likelihood of a favorable outcome. Disputes between clinical faculty members and their universities or health care institutions pit individuals against organizations with substantial resources, expertise and power. For this reason, even effective mechanisms to adjudicate academic freedom disputes are insufficient to protect clinical faculty. Unless a clinical faculty member has meaningful representation, workplace disputes are overwhelmingly one-sided, and rights on paper are difficult, if not impossible, to enforce.

In her battle with the University of Toronto, Nancy Olivieri ultimately triumphed because UTFA and CAUT were willing to spend well over half a million dollars in her defense. The University of Toronto is well aware of this requirement for effective faculty defense and made changes to its policy for clinical faculty that makes it harder for UTFA to defend them.^{11, 12, 13, 14, 15}

To ensure academic freedom, clinical faculty must join or create effective organizations to represent them with respect to universities and university-affiliated health care institutions. These organizations should be characterized by a democratic structure, financial viability and independence, a legally enforceable collective bargaining relationship with the institution, the exclusion of persons in managerial positions, participation in the broader academic staff community, and intimate familiarity with academic freedom issues. Where membership in existing certified associations or creation of new certified associations is not possible or feasible, clinical faculty should create robust uncertified associations. Such associations would be similar to faculty associations at non-unionized universities that negotiate collective employment contracts and enjoy access to automatic contributions to faculty representative organizations and independent grievance arbitration mechanisms.

COMMENTARY

Experience in Canada suggests that violations of the academic freedom of clinical faculty are an increasing problem. Why? Tensions exist between corporate goals of universities and hospitals and their commitment to the academic freedom of individual faculty. In

part, this is due to the increasing dependency of academic health science centers upon private-sector industrial sponsorship, both from the pharmaceutical industry and independent wealthy donors. Increasingly, administrators and institutional leaders view health care as just another business, interested in maximizing efficiencies, and often in maximizing revenue. The language and attitudes of the private-sector corporate world increasingly dominate discourse in hospitals and universities. In such an environment, it is not surprising that traditional values of academic freedom are seen as less relevant, and less worthy of aggressive defense.

As academic health centers embrace corporate models of managerial control that undermine the collegial governance traditions of the university, tensions increase. Health care institutions intent on creating, both internally and externally, a positive face to the public, will be understandably unenthusiastic about adverse criticism from their faculty. Administrative leaders frequently fail to recognise that accepting criticism is sometimes a prerequisite for optimizing patient care and fostering scientific discovery.

University leaders, increasingly focused on corporate goals, may be tempted to take punitive action against faculty members whose behavior threatens those goals.

Unfortunately for many clinical faculty, universities have not provided the same levels of protection for the rights and academic freedom of clinical faculty as for other faculty.

Universities must not only ensure that the academic freedom of clinical faculty is protected in the university context, but must use their influence with affiliated health care institutions to see that they also protect academic freedom for clinical faculty.

Clinical faculty are particularly vulnerable because – in contrast to almost all non-clinical faculty – they very seldom have access to faculty association agreements and independent dispute resolution mechanisms. As a result, clinical faculty must themselves act vigorously and assertively to defend their academic freedom.

Universities and affiliated health care institutions must make strong declarations of academic freedom rights, provide security of appointment and income, allow access to dispute resolution systems characterized by natural justice, and permit clinical faculty to form powerful representational organizations. These steps are necessary to maintain the ability of clinical faculty and the institutions where they work to advance the boundaries of scientific knowledge and improve clinical practice.

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