Authors’ conflicts of interest in Nepalese healthcare journals

MOHAN RAJ SHARMA, SUBIGYA PARAJULI, LAVA SHRESTHA, GOPAL SEDAIN, PRAKASH KAFLE

Abstract
Most biomedical journals now require authors to declare their conflicts of interest (COI), especially financial ones, before they accept the manuscript for submission. This study aims to examine the COI policies of Nepalese healthcare journals. The sample constituted journals indexed in Nepal Journals Online (NepJOL) as of June 2021. Of the 68 that met our inclusion criteria, 38(55.9%) journals endorsed the COI policy of the International Committee of Medical Journal Editors. Thirty-six (52.9%) journals had a policy for reporting the COI. Financial COI was the only type of COI mentioned. All journals in Nepal are encouraged to request the authors to declare the COI for better transparency.

Keywords: conflict of interest, healthcare journals, journal policy, Nepal, research ethics

Introduction
A conflict of interest (COI) exists when an individual or an institution has two or more overlapping, and often contradictory, interests in an activity. The Institute of Medicine, US, defines COI as “circumstances that create a risk that professional judgments or actions regarding a primary interest will be unduly influenced by a secondary interest” [1]. As the role of a clinician has widened with many serving as investors or part-time consultants in pharmaceutical companies and with the increasing involvement of pharmaceutical and other industries — such as tobacco, alcohol, food and beverage — in medical practice, the topic of COI is emerging as a powerful concept in research and publication ethics. Food and beverage industries often try to portray their products as healthy, whereas tobacco and alcohol industries try to downplay the ill effects of their products [2-4]. Financial COI is most common, though other forms of COI also exist [5, 6]. Financial COI includes but is not limited to stock ownership, grant/research support, direct employment, and serving as an advisor, consultant, or public advocate of the company [5]. Non-financial forms of COI include professional, intellectual, and personal conflicts [7]. Other types of COI, such as that of editors or reviewers, do exist but are not the subject of our study.

In healthcare research, COIs are widespread [8]. Studies have revealed that industry-funded research is more likely to derive conclusions in favour of the industry [9-11]. Given this context, the readers of a scholarly paper need to know the type and extent of the authors’ COI to interpret the results critically. Hence, declaring a COI appropriately and honestly is the responsibility of every author. Failure to do so not only erodes public trust in research reports but also misleads healthcare professionals, which may have dire consequences.

Journals have a unique responsibility of ensuring that the author makes appropriate disclosures. Many prestigious international organisations — such as the International Committee of Medical Journal Editors (ICMJE), the World Association of Medical Editors (WAME), and the Committee on Publication Ethics (COPE) — have published guidelines with specific recommendations stated explicitly on their website for the disclosure of information about authors’ COI [1, 12-14]. COPE is a subscription-based organisation that opines on case studies, whereas WAME is a discussion-based forum open to all editors. ICMJE, on the other hand, is an invitation-only committee that provides recommendations. Though there is a significant overlap, the three have different roles in promoting and enforcing publication ethics as well as different powers. COPE’s code of conduct recommends editors to have clear definitions of COI and processes for handling them [13]. WAME has specific guidelines regarding declaring and managing a COI [12]. Similarly, the ICMJE recommends publishing articles with statements declaring the authors’ relationships with the organisation, the source and nature of support, and the nature of involvement during the different phases of research. The ICMJE also encourages all journals endorsing its criteria to use the disclosure form developed by their committee [14]. Though none of the
recommendations from these organisations is legally binding, they are considered important by the journal-editing community. Therefore, all journals are strongly advised to make their COI policies publicly available and readily accessible [12]. We believe that a journal’s COI guidelines should include a declaration, a mechanism of investigation, and potential action from the journal if an undisclosed COI is found. However, adherence to these ethical aspects varies across journals. Several studies evaluate the existence and content of the COI policies of journals across the world [6, 15-16], but a similar study has not yet been published in Nepal.

Therefore, the primary objective of this study is to determine the proportion of healthcare journals published in Nepal that disclose their policies on their websites. The secondary objective is to describe their degree and pattern of adherence to standard COI policies as specified in the ICMJE guidelines [14].

Methods

Using the Nepal Journals Online (NepJOL) database (maintained by the Tribhuvan University Central Library in Nepal), we reviewed all healthcare-related journals published in the English language, as of first week of June 2021 [17]. NepJOL is a comprehensive database that lists all journals that fulfill a minimum set of standards and ranks them based on quality. NepJOL follows the Journal Publishing and Practices Standards (JPPS) criteria, designed specifically for developing countries. It assigns journals one of six levels (new title, inactive title, no stars, one star, two stars, and three stars) based on the publication of original research, a well-functioning editorial board, an accurate description of the peer-review process, the availability of authors’ guidelines, and the display of editorial and publishing policies. Details of the ranking criteria can be found on the JPPS website [https://www.journalquality.info/en/jpps-criteria/] [18].

As the information was publicly accessible, approval from the institutional review board (IRB) was not sought for this study. We identified 68 healthcare journals listed in NepJOL. All medical, dental, nursing public health colleges, and professional societies related to healthcare were enquired regarding the publication of an institutional journal. Altogether, 69 healthcare-related journals were found, of which, one was not listed in the NepJOL database, and hence, excluded from our study. We studied the “Information for Contributors” section of each journal in detail and analysed its COI guidelines. In particular, we looked at whether a journal mentioned a COI policy and what it consisted of. In journals that did not display this information or when the information was unclear, one of us registered as an author on their submission system to read the author’s guidelines to get the desired information.

The journals were divided based on their JPPS ranking, subject category, endorsement of COPE, WAME, or ICMJE, and journal affiliation to professional organisations or academic institutions. To retrieve data on COI disclosure requirements, we searched the page on information for the contributors for words or phrases such as “Conflict of Interest,” “financial disclosure,” “funded by,” “support,” “association,” “competing interests,” “relationship,” “employment status,” “affiliation,” and “acknowledgements.” The explanation of these words and phrases was analysed to find out the actual definition provided by each journal. Specifically, the following components were recorded:

- Presence or absence of a disclosure policy.
- If the journal had a COI disclosure policy, the type of COI mentioned (financial or others).
- If financial, the amount of payment and duration of employment or stock-holding.
- The journal’s policy regarding barring certain industry-related manuscripts (manuscripts discussing the benefits of food and beverages or the decreased harm of tobacco and alcohol).
- Policy description of how COI disclosure affects the manuscript review process.
- Policy description of how non-disclosure of COI affects the review process.

Though the last two points were not mentioned as standard components by WAME, COPE, and ICMJE, a previous report evaluating these among public health journals [5] prompted us to analyse these aspects in Nepalese journals as well.

For descriptive data presentation, we used frequencies and percentages to describe the categorical variables.

Results

A total of 226 journals were listed in the NepJOL database, of which 68 healthcare related journals met our inclusion criteria.

Journal ranking

Table 1 displays the ranking status of the journals on NepJOL. “Two stars” and “Working towards ranking” were the most common categories.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Number of journals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactive</td>
<td>7 (10.3)</td>
</tr>
<tr>
<td>New</td>
<td>11 (16.2)</td>
</tr>
<tr>
<td>Working towards ranking</td>
<td>17 (25)</td>
</tr>
<tr>
<td>One star</td>
<td>15 (22.1)</td>
</tr>
<tr>
<td>Two stars</td>
<td>18 (26.5)</td>
</tr>
<tr>
<td>Three stars</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
</tr>
</tbody>
</table>

Subject category of the journals

Table 2 shows the subject category of the journal. Multispecialty journals — covering all clinical fields like
Table 2. Subject category of the journals in the NepJOL database

<table>
<thead>
<tr>
<th>Subject category</th>
<th>Number of journals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multispecialty</td>
<td>35 (51.5)</td>
</tr>
<tr>
<td>Public Health</td>
<td>6 (8.8)</td>
</tr>
<tr>
<td>Dentistry</td>
<td>3 (4.4)</td>
</tr>
<tr>
<td>Laboratory Medicine</td>
<td>3 (4.4)</td>
</tr>
<tr>
<td>Neuroscience</td>
<td>3 (4.4)</td>
</tr>
<tr>
<td>Others/Subject-specific:</td>
<td>18 (26.5)</td>
</tr>
<tr>
<td>One each from Anaesthesiology, Cardiology, Dermatology, Endocrinology, General Surgery, Infectious Disease, Internal Medicine, Obstetrics &amp; Gynaecology, Oncology, Ophthalmology, Orthopaedics, Otorhinolaryngology, Pathology, Paediatrics, Pharmacy, Physiology, Psychiatry, and Radiology</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>68 (100)</td>
</tr>
</tbody>
</table>

Journal affiliation

Thirty journals were published by professional societies, 19 by individual medical colleges, and seven by universities and academies. The remaining were published by departments of universities and colleges, individual hospitals, or nongovernmental organisations.

Endorsement of COPE, WAME, or ICMJE

Thirty-eight (55.9%) journals endorsed the ICMJE policies, 20 (29.4%) endorsed the COPE, and 13 (19.1%) endorsed policies that of WAME. Only 12 (17.6%) journals endorsed the policy of all three organisations. One journal endorsed the policy of WAME only, six journals endorsed the policy of both ICMJE and WAME. Twenty-nine journals did not endorse any of these organisations’ policies.

COI statement policy

Out of the 68 journals, 36 (52.9%) had a COI policy explicitly stated on the “Information for Contributors” page. Table 3 shows the number and percentage of journals with a COI policy for each rating.

Of the 38 journals that endorsed ICMJE guidelines, 13 (34.2%) did not have a COI statement. Whereas, of the 30 journals that did not endorse ICMJE guidelines, 13 (43.3%) had a COI statement.

Table 3. Journals providing a COI policy and their ratings (n = 36)

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New and inactive</td>
<td>8/18 (44.4)</td>
</tr>
<tr>
<td>Working towards stars</td>
<td>10/17 (58.8%)</td>
</tr>
<tr>
<td>One star</td>
<td>7/15 (46.7%)</td>
</tr>
<tr>
<td>Two stars</td>
<td>11/18 (61.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>36/68 (52.9%)</td>
</tr>
</tbody>
</table>

Table 4 shows the relationship between the subject category of journals and the COI policy statement. Forty-four journals that have published at least two journals in one category were analysed.

Table 4. Subject category of the journals and the COI policy statement (n = 44)

<table>
<thead>
<tr>
<th>Journal Type</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multispecialty</td>
<td>20/35 (57.1)</td>
</tr>
<tr>
<td>Public Health</td>
<td>2/6 (33.3)</td>
</tr>
<tr>
<td>Dentistry</td>
<td>1/3 (33.3)</td>
</tr>
<tr>
<td>Total</td>
<td>23/44 (52.3)</td>
</tr>
</tbody>
</table>

Only 21/36 (55.3%) journals further elaborated on COI with examples. All 36 journals mentioned only financial COI in their COI description. Only four (11.1%) journals mentioned that the manuscript would not be sent to a peer reviewer working in the same organisation as the author.

Out of 68, only one (1.5%) journal required the authors to mention the amount and duration of funding. ICMJE recommends authors to declare the support received for the ongoing manuscript without any time limit, whereas the time frame for the disclosure of items such as grants, royalties, consulting fees, and honoraria is 36 months (14).

None of the journals mentioned the degree of independence from the funders, while drafting and submitting the manuscript. No journal mentioned any policy regarding manuscripts funded by certain industries such as tobacco, alcohol, food and beverage. None of the journals had any description of non-disclosure of COI affecting the review process.

Discussion

Relationships between researchers and manufacturing
companies such as those of drugs, devices, and tests have the potential to be exploited such that the financial and other interests of the researcher may conflict with the pure aim of advancing medicine [20]. To strike a balance, IRBs and data safety and monitoring boards (DSMBs) regulate the COI during the research process while journals are expected to evaluate the COI during the publication process [21, 22]. Hence, many leading medical journals adopt a policy of authors declaring the degree and magnitude of COI [5,6,15]. Multiple studies published in Europe and North America have explored journals’ adherence to COI policies [6-8, 16]. Data on this topic specifically from South Asian journals are scarce [20, 23]. This is the first study in Nepal that investigates this important part of the publication process in 68 healthcare journals across more than 21 healthcare specialties.

**General characteristics of the journals**

In our study, 12 (17.6%) of the 68 journals mentioned that they followed the guidelines of all three organisations — COPE, WAME, and ICMJE. Thirty-eight (55.9%) journals mentioned that they followed the ICMJE guidelines, 13 (19.1%) endorsed WAME guidelines, and 20 (29.4%) endorsed those of COPE. In the study of public health journals by Daou et al [5], only 21% of the journals were members of the ICMJE and 67% were members of COPE. While in a study of 256 high-impact journals by Blum et al [6], only 69 (26.9%) journals had officially endorsed the ICMJE guidelines. Most journals endorsing ICMJE guidelines had COI policies compared to the 84% of journals not endorsing the guidelines (68/69 versus 158/187) [6].

Dal-Ré et al in 2018 studied “highly influential” journals based on the 2017 Journal Citation Reports [24]. They found that 45% (58/130) of these journals followed the ICMJE recommendations and 73% (95/130) were COPE members. There was no correlation between the membership of these organisations and the display of the COI policy. Bose et al, in their analysis of 106 Indian biomedical journals, found that 61 (57.5%) journals endorsed all three international guidelines [23].

**COI statement policy**

In our study, 52.9% of the journals displayed COI policies on their website, which is smaller in comparison to Blum et al where 89% of medical journals had COI policies [6]. Daou et al found that 90% journals had a policy of reporting funding information [5]. This is in contrast to results obtained by Ancker et al, where only 33% (28/84) journals reported COI [16]. However, this study included journals from nonmedical subjects as well. Similarly, in another research of 53 bioethics journals by Master et al, 57% had COI policies for authors [25].

The star rating by JPPS criteria is given only when a journal meets a certain standard and has strong ethical policies [18]. Moreover, the ranking system of JPPS does not seem to incorporate COI policies while categorising the journals. Only three-star journals require the disclosure of funding acknowledgement [18].

**Elaboration of the COI policy**

In our study, of 36 journals, 21 described the actual meaning of COI, though this is surprisingly low compared to the published literature. In Blum et al, 77% had defined the meaning of COI [6]. While only 33% of journals adequately explained COI in biomedical publications from India as per Bose et al [23].

Discussions on the amount and duration of financial support are even more scarce. This is especially important if the study is related to the advancement of a new device or product. Daou et al found that none of the public health journals studied by them described the amount and duration of financial support [5]. In our study, only one journal described the amount and duration.

**Effect of disclosure/non-disclosure of the COI on the manuscript evaluation process**

Biomedical journals have largely remained silent regarding the effect of a disclosure of a COI on the editorial process. No journal in our study shared this information. In 2017, Daou et al found that 19% of the public health journals described the effect of COI disclosures on the editorial process [5]. The authors also noted that 10% of the journals mentioned a potential impact of not disclosing COI on the editorial process (eg, editors may correct, reject, or retract the publication). According to Cooper et al, 11% of the journals had a policy of restricting author submissions based on COI [15]. Master et al found that 31% of the journals specified that depending on the nature of the COI, the article might not be published [25]. They also found 17% of journals with a COI policy that stated certain penalties for authors for non-compliance, such as retraction of the article.

Regarding autonomy of publication, everyone believes that the authors should be as independent as possible, although the pressure from big industries can be huge [9,10,26]. For example, some industries require that the final manuscript be approved by them before submitting it to the journal. In our study, we found that none of the journals required the authors to disclose the contract between the authors and funding agencies.

**Recommendations for the journal editors**

Our study provides new data on the availability and content of the COI policies of the healthcare journals in Nepal. Though the findings are not discouraging, there is room for improvement. We recommend the following based on our findings:

1. Journals should explicitly state their COI policy on their website. The policy should clearly state how will the COI be verified and what will be the fate of the paper if the authors are found to state the COI dishonestly.
2. There should be some uniformity across all journals in
terms of the minimum information required by the authors to indicate COI. Formulation of guidelines by the national society of healthcare journal editors will be a welcome step in this regard.

Limitations
We analysed journals listed only on NepJOL. Among those, only one healthcare journal was not included in the analysis.

Conclusion
This study reflects the COI policy of nearly 99% of healthcare-related journals from Nepal. Slightly more than half have a policy regarding authors’ COI declaration. However, many do not provide details on COI and the mechanisms to tackle nondisclosure or dishonest disclosure of COI in the “Information for Contributors” section. More healthcare journals from Nepal should have a policy requiring transparent reporting of COIs so that journals comply with international standards. This article concentrated only on the authors’ COI. In future, comprehensive studies on COI involving authors, editors, and reviewers should be conducted. Also, though inclusion is not mandatory, all Nepalese journals are encouraged to apply for enlistment on the NepJOL database to increase their visibility.

Conflict of Interest:
1) Mohan Raj Sharma: Ex-editor-in-chief of Nepal Journal of Neuroscience; Ex-executive editor of Journal of Institute of Medicine, Nepal; Editor of Journal of Neurosurgery in Rural Practice; Chairperson of Institutional Review Committee, Institute of Medicine, Nepal.


4) Subigya Parajuli and Prakash Kafle: None declared.

Source of funding: None declared.

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23. Bose D, Nasta S, Ravi R, Thatte UM, Gogtay NJ. An audit of reporting of conflict of interest policies among three stakeholders in Indian
Abstract
To understand the concept of dignity in care and use it in practice, nurses need a clear understanding of the dignity of patients, which can help them improve quality of care and provide services of a higher standard. This study aims to clarify the concept of human dignity of patients in nursing. Walker and Avant’s method (2011) was used for this concept analysis. Published literature from 2010 to 2020 was identified using national and international databases. The full text of the included articles was reviewed. The main dimensions and attributes include valuing the patient, respecting patients’ privacy, autonomy, and confidentiality, having a positive mental image, having a sense of altruism, respecting human equality, observing patients’ beliefs and rights, adequately educating patients, and paying attention to secondary caregivers. Nurses should consider the subjective and objective aspects of dignity in their daily care activities by cultivating a deeper understanding of the concept of dignity and its attributes. In this regard, nursing tutors, managers, and policymakers in healthcare should emphasize human dignity in nursing.

Keywords: concept analysis, human dignity, patient, nursing

Introduction
The concept of dignity has a long history spanning from prehistoric times to the advent of modern ethical and legal discourses. Traditional concepts such as Imago Dei (Image of God), wisdom, freedom, natural law, and conscience are based on interpretations of dignity [1]. Various religions and philosophers throughout history have provided diverse interpretations of the concept. In the twentieth century, the Universal Declaration of Human Rights was the first document to integrate the concept of human dignity in a global legal framework. The Declaration states that all human beings are born free and with equal dignity and rights [2]. The term “dignity” is defined as entailing respect and self-worth and overlaps with concepts such as hope, self-exaltation, self-confidence, quality of life, and self-respect [3].

Dignity is a subjective concept that is interpreted differently by individuals and cultures [4]. It can be classified into “absolute dignity” and “relative dignity”. The former is a universal value and is based on human rights. All human beings are valuable because they are human, regardless of their situation and condition [5]. Maintaining the dignity of patients in healthcare systems is important [6]. Absolute dignity is the same for all human beings and does not change, while relative dignity can change and is influenced by culture, society, and education [5, 7]. Thus, in recent decades, much attention has been paid to exploring the nature of human dignity and its relationship to healthcare practices [8-12].

Preserving a patient’s dignity and value and respecting their human rights are critical to nursing [13, 14] and are specified in nursing ethics codes [15]. Nevertheless, patients are still at risk of losing their dignity [16] at the hands of the nursing staff, which may influence the provision of respectful care [16, 17]. Several studies indicate that dignity is not respected in care settings. A lack of respect for human dignity is associated with negative feelings such as fear, disbelief, shock and denial, anger, hatred, apathy, sadness, and

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Published online first on September 2, 2022.
Manuscript Editor: Mala Ramathan
Peer Reviewers: Jagriti Gangopadhyay and an anonymous reviewer.

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