this group there was no significant effect modification of any one of the four risk factors on the association between job strain and coronary artery disease. Therefore, the conclusion is irrelevant for the majority of the workers with job strain. Job strain, an adverse working condition, may be a structural barrier that keeps workers from adopting and maintaining healthy behaviours as implied in another article[4] by the same research group.

Last, throughout the article, the authors equate job strain with perceived work stress or work stressors in general. The authors inappropriately compared the effects of perceived work stress (i.e., how often participants felt stress at work) in the INTERHEART study with job strain in their study.[1] Equating job strain with work stressors in general ignores other important work stressors (i.e., poor workplace social support, job insecurity, long work hours, and effort–reward imbalance) that have been associated with cardiovascular disease.[5]

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Doctors must be trained to assess credibility

According to research highlighted in a *CMAJ* news article,[1] Canadian schools are not adequately managing conflicts of interest in undergraduate medical education. Persaud, whose research is discussed in the article, rightly suggests that medical students do not yet possess the knowledge and experience needed to detect biased information. But do trained physicians have the skills to do so?

Lo and Ott[2] reported that conflicts of interest are ubiquitous in continuing medical education, and that doctors are underprepared for the task of recognizing when conflicts are influencing the content presented. Lo and Ott[2] point out that bias, which undermines the scientific validity of our knowledge, results not only from methodologic shortcomings of research but also from conflicts of interest arising in research or education. Yet, current undergraduate and postgraduate medical training emphasize only the methodologic determinants of systematic bias, and critical appraisal — our evidence-based approach to assessing the quality of evidence — is tantamount to assessing the rigour of a study. In other words, was the study well designed?

The credibility of the source of our information is another crucial consideration that is underappreciated and unexplored.[3] Is the source reliable? Can we trust in the completeness and integrity of the evidence presented, or are important data missing or are facts potentially distorted? Of serious concern is the credibility of much pharmaceutical industry–funded education and research, which are fraught with publication bias and other forms of misrepresentation.[4]

Assessing credibility requires an understanding of the sociocultural, financial and regulatory context of research and education, as well as an approach, just as we have an approach to the critical appraisal of study design. First, we must recognize that poor credibility is as significant — perhaps even more significant — a threat to the validity of our knowledge as poor methodology. So we had better train physicians to assess it.

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Correction

Atlantic Canada being served for cancer genotyping

A news story that appeared in the Oct. 1, 2013, issue of *CMAJ* incorrectly stated that Atlantic Canada has no facility to test for crucial genetic mutations that could improve some patients' treatment options. In fact, a Halifax-based screening program was launched in September 2012 and has subsequently tested more than 500 cases from throughout the region, and offers this additional level of care to qualifying individuals from all four provinces. *CMAJ* apologizes for any this error and omission.

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