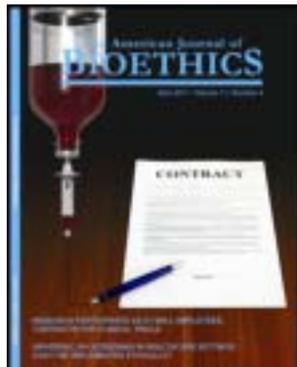


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Editorial

Beyond a Pejorative Understanding of Conflict of Interest

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In seeking to clarify the concept of conflict of interest (COI) in debates about physician–industry relationships, Howard Brody (2011) highlights the extent to which the problem turns on a common pejorative understanding of COI. Whether it is the academic or public policy “pharmapologists” or “pharmascolds” talking about COI, there is often a straightforward and overly simplistic correlation made: that is, a conflict of interest—by definition—leads to fraudulent or corrupt behavior. The same type of reasoning is commonly found in discussions about COI outside the health sciences, most notably in news stories about the awarding of government contracts or the behaviour of corporate executives (see the businessethicsblog.com for discussion of some examples). The problem is that in focusing on dramatic failures to manage COI (e.g., around Vioxx), there is a tendency to strongly associate COI with extreme forms of financial and even criminal misconduct, leaving the public, policymakers, academics, and professionals with a skewed and limited understanding of the concept. The implication is that the *only* interests at stake are financial so there is no room to consider the influence of nonfinancial personal (e.g., career advancement) or institutional (e.g., reputation) interests. Those people who find themselves in a COI must be *bad* or *unethical*; it is not possible to reflect on the circumstances or institutional structures that might have contributed to the conflict, or perhaps even made it inevitable. This conception of COI is so value-laden and pejorative that it gets used as a trump card—“Stop, there’s a conflict of interest!”—and all conversation or debate about the interests at stake or how to manage any conflicts ceases instantly. We are left with prejudicial assumptions of the form “that person is bad (but not me)” and inadequate judgments such as “I’ve been transparent so there’s no more COI” (Cain, Loewenstein, and Moore 2005). As a result, individuals may be likely to hide their COI (if they even recognize it), scared of the consequences that disclosure could bring to their career and reputation, or they may try, often unsuccessfully, to manage alone their COI. Open discussion is simply not an option.

Brody’s call for more clarity in the use of the concept of COI is important and should, I suggest, be an opportunity for those of us in the bioethics community to take a closer look at the issue. Financial COIs are clearly a significant

challenge in medicine and the health sciences (although they are not exclusive to these domains), and something that has rightly received enormous academic and public policy attention (Rochon et al. 2010; Boyd and Bero 2007). It is essential to have in place policies to help identify and mitigate those financial interests that put at risk the confidence of colleagues, students, and the public in health sciences and academic research. But financial interests are not the only source of conflicts, even if they are the most “visible” and discussed; personal or institutional interests may also lead to COI, situations made all the more challenging by the fact that such interests are often completely ignored.

As I’ve commented in my blog (conflict-of-interest.net) and elsewhere (MacDonald and Williams-Jones 2009), COIs are not inherently unethical; sometimes professional and institutional arrangements make COI likely, even inevitable. For example, as a professor I both evaluate (e.g., grade) my graduate students and promote them through letters of recommendation (for scholarships, positions), and I arguably have an interest (e.g., building my academic curriculum vitae [CV], promotion) in seeing my students succeed in their studies and future careers. These responsibilities and nonfinancial interests could well bias my judgment (Sugarman 2005). But they are also often unavoidable (who better to write letters for students than their supervisor?), so we must reflect on the associated risks or harms of such COI, and then compare these with the benefits and harms of various approaches to managing them (transparency? self-critique or group critique? removal from decision making?). What matters, ethically speaking, is that individuals and institutions have at their disposal effective tools to help them deal appropriately with COIs when they arise (Davis and Stark 2001). In practice, however, such tools for identifying and managing COI may be all too limited in terms of their usefulness.

In the academic community, a primary source of guidance comes in the form of national, regional, and institutional policies, sometimes as specific documents (e.g., journal or institutional COI policies) but also often under the heading of research integrity and research ethics guidelines. My study of formal university COI policies found that these documents were often too narrow (focused on

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financial COI) and/or legalistic and generally hard to read (Smith and Williams-Jones 2009; Williams-Jones and MacDonald 2008). When these policies were well written, they were often neither widely known within the institution nor combined with procedures to help people actually understand and manage the range of interests that might lead to COI. Institutional policies seem more often aimed at protecting the institution from legal liability than at helping researchers understand and manage COI.

As with other ethically complex problems, good policy documents can provide only a partial solution. Other mechanisms, such as discussions about a university's norms and values (Ferguson et al. 2007), will be important means of fostering an ethical culture of research and academic practice among students, researchers, and administrators. But as those of us who have been involved with teaching ethics or participated in research ethics review can attest, building such a culture of ethics in academia (and clinical practice) is an uphill battle, and it will be no less challenging with regard to COI. The latter concept is still widely associated with "bad people" or those who work in the biosciences and take "money from Big Pharma," so getting academics or health professionals to recognize that they too can find themselves in COI will be difficult. That being said, I think such a task is possible, but it means going beyond public forums and spending the time and money to organize regular, formal ethics training initiatives (e.g., online courses as some universities have started offering, annual workshops, or seminars in research methods courses) that can help individuals and institutions better identify COIs when they arise, understand their consequences, and learn to manage them when they cannot be avoided.

The crucial point to remember is that academics and health professionals often have a very limited understanding of what COI is, what is ethically problematic, and how it should be managed. The concept of COI needs greater clarity in public and academic discussions, as Howard Brody has noted in his article, if debates about it are to be constructive. But our understanding of the concept also needs to be transformed to (1) remove its pejorative connotations ("COI is Bad!"), and (2) expand its scope to include nonfinancial personal and institutional interests, so that (3) people come

to recognize that COI is something that we often have to *live with* and *manage*. ■

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