Clarifying the Dispute over Academic–Industry Relationships

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Howard Brody (2011) accuses those generally supportive of academic–industry relationships (“pharmapologists”) of impugning the notion of conflict of interest as they defend such relationships against the attacks upon them mounted by industry skeptics (“pharmascolds”). He seeks to clarify the problem of conflict of interest in medicine while rebutting pharmapologist attacks on that notion and hence on pharmascold policy recommendations for academic–industry relationships. While the concept “conflict of interest” could perhaps use some clarification, I think Brody has mistaken its importance in the dispute over academic–industry relationships. Pharmapologists are not as dismissive of the notion as he suggests—but they do have a different view of its bearing on academic–industry relationships than do the pharmascolds. The difference follows from the differing views of the world held by the two groups—a difference that I hope to clarify in the following remarks about Brody’s analysis.

Brody’s definition of conflict of interest, while close to standard definitions, is a bit too narrow. He is willing to acknowledge a conflict of interest only if a potentially conflicted person enters into “certain social arrangements,” which remain unspecified. A broader definition is preferable, such as that of Carson, who holds that a conflict of interest is present if a person (a) has duties to another party by virtue of holding an office or position and (b) is impeded in performing those duties by (c) interests that are incompatible with the duty (Carson 2004). By this definition, whether a person is impeded depends upon a judgment made by a “reasonable person” that a person of ordinary moral virtue would be impeded and, most importantly (and here differing from Brody), there is no limitation on the kinds of interests that might be recognized as conflicting. The virtue of such a broad definition is its recognition that conflicts of interest are ubiquitous and hence demanding of prudential assessment rather than summary acceptance or condemnation.

Brody’s narrower definition serves his purpose by suggesting at the outset that some conflicts of interest, those involving yet-to-be-specified social arrangements, are more worrisome than others. He proceeds to argue that financial conflicts of interest are uniquely dangerous and worrisome, as against the alleged pharmapologist position that such conflicts are unimportant because they “make up only a tiny . . . segment of the total picture” (XX). But the point to make about the ubiquity of conflicting interests is not that financial conflicting interests are thereby unimportant (a point that the pharmapologists cited by Brody do not make, as far as I can tell). It is that one should go carefully in deciding how any conflicting interest, financial or otherwise, should be handled. Removing one conflicting interest may simply open the way for the operation of others. Human decision making does not occur in decision frames that can be purified from conflicting interests. The best we can do is to protect against certain kinds of interest amenable to removal while running the risk of thus giving other interests a higher likelihood of achieving influence.

What follows is not that financial conflicts of interest should be summarily forbidden, but that such conflicts should be carefully scrutinized and judged according to their risks and benefits in individual circumstances. Brody offers several reasons for a more militant approach, none of them persuasive. Pharmapologists may overweight the benefits of financial conflicts of interests compared to the risks; they may indeed, but this will not lead to malfeasance unless pharmapologists are setting the rules, which they will not be doing without the input of pharmascolds such as Brody, who may be equally likely to underweight the benefits. Brody goes on to suggest that financial conflicts should be given no quarter because benefits accruing from such conflicts cannot be weighed against the dangers posed by them (“advocacy for the patients’ health represents a duty and not a mere interest; hence the existence of a competing benefit is insufficient to overturn it”) (XX). But this assertion is unsupported. It is exactly the paramount importance of a physician’s duty to patients that demands our careful assessment of interests that may conflict with that duty in terms of risk and benefit. If a given conflicting interest has compensating benefits for physician decision making and our aim is good physician decisions, such benefits need to weighed against the threat posed by the conflict. Finally, Brody cites Greenland’s suspicion that an investigator’s relationship with a sponsor might affect his results (Greenland 2009) as a reason to conclude that financial...
conflicts of interest are in a class by themselves. But this conclusion does not follow, as Greenland himself acknowledges. Contra Brody, although financial conflicts of interest are quantifiable and comparable (to one another) in ways that other sorts are not, they are not more or less threatening to decision making than those other sorts of conflicts.

Having defined conflict of interest in terms of nefarious social arrangements and then specified the latter as financial conflicts, Brody offers conditions that, if met, would determine conflicts of interest to be “morally blameworthy in themselves.” These include (a) arrangements carrying a “serious risk of threatening the public trust” in physicians, that are (b) avoidable. On the view I would oppose to Brody’s, while entering into certain conflicts of interest might indeed be judged morally blameworthy, the blame attaches after the risk–benefit calculation rather than beforehand; Brody’s formula does not get us to the conclusion that the rest of his argument has failed to reach, that financial conflicts of interest are morally blameworthy simply by virtue of being what they are. A further difficulty with Brody’s formula for conflicts of interest to be proscribed is his appeal to the “public trust” as the entity under threat. Brody would be better advised to seek the protection of the public itself rather than its attitudes. The latter are highly malleable, and the standard implied, the “appearance of a conflict of interest,” is troubling, not only for its vagueness (who is to say when a given appearance is troubling?) but for its invitation to frivolous accusations of malfeasance (Rotunda 2005; Morgan and Reynolds 2002). It is of course true that some appearances are sufficiently troubling to forbid, but our standard of probity should generally be the avoidance of real wrong, not the mere appearance of wrong.

Brody and his fellow pharmascolds have been successful enough in their attack on the pharmaceutical industry that public suspicion of that industry is likely at an all-time high. While some of this suspicion has, of course, been amply justified by physician and industry misdeeds, the overall condemnation of physician–industry connections that some have gone on to offer (Schafer, 2004) has not been, and it would be tragic if the connections between academia and the American pharmaceutical industry to which we owe so many new drugs in the past 40 years were to be severed because such connections now appear suspicious as a result of pharmascold agitation.

Carson’s definition of a conflict of interest, with its implied requirement for prudential assessment, would lead to a rather different recommendation for physicians than that offered by Brody. It might go as follows: Physicians should avoid a conflict of interest if (a) the balance of risk and benefit presented by the conflicting interest to the physician’s duty offers a net threat to the performance of the duty and (b) the conflicting interest is removable. This recommendation would reserve moral blame for entering into conflicts of interest for which the risk–benefit calculation is clearly adverse to the removable interest. The practical problem is, of course, where to draw regulatory lines. Brody and his fellow pharmascolds favor the removal not only of all financial conflicts of interest involving medicine and industry but also the prescribing of activities, such as pharmaceutical detailing, that likely offer significant benefits to physician prescribing (and some accompanying dangers), without presenting a worrisome conflict of interest on any current definition. Pharmacologists seek the continuance of some carefully scrutinized financial relationships and a permissive stance toward pharmaceutical detailing.

Differences over the concept of conflict of interest between pharmascolds and pharmacologists (as per my argument here, there likely are some such differences) do not suffice to explain the two groups’ vastly differing policy preferences for regulating academic–industry relationships. It is more likely that broader differences of worldview explain disagreement over both conflict of interest and regulation of academic–industry relationships. Take the example of hospital formulary committees. At the risk of overgeneralizing, I take it that pharmascolds would favor prohibiting physicians with ties to a pharmaceutical company from being members, whereas pharmacologists would favor a liberal membership regime, with members recusing themselves from voting on drugs made by companies to which they had ties. The pharmacologist recommendation most likely reflects not a rejection of the notion of conflict of interest but instead a conviction that the conflict in this case should be judged prudentially, accompanied by a judgment that the risks and benefits of company ties for formulary decision making favor allowing company ties among members but not voting by such members on decisions about their company’s drugs.

The pharmacologist judgment here follows from the pharmacologist view of the world: Conflicts of interest are ubiquitous; that is, human decisions are subject to distorting influences that are pervasive and, in the aggregate, inescapable; removing particular financial conflicts of interest from decision making on a formulary committee will simply make more room for other kinds of bias, such as prejudice against pharmaceutical companies and their brand-name drugs. The problem to be confronted is not a single subset of conflicting interests (that is, financial) but the universe of passions and interests that may contaminate rational thought. The best protection against such contamination is not wholesale removal of a single subset of conflicting interests, but instead a diversity of voices among those making decisions, among whom we may hope that countervailing biases will be neutralized. Such a diversity would also ensure that we are not losing valuable expertise or competence by excluding given classes of committee members, such as physicians with industry connections. Of course, some particular removable interests should be removed: hence the prohibition on members voting on drugs made by companies in which they have an interest.

1. See remarks beginning with “Although I have focused on distortion from financial input, I have no doubt that ideological commitment can be just as distortive” (Greenland 2009, 597).

2. As I have argued elsewhere (Huddle 2007; 2010).
The pharmascold recommendation for restricted formulary committee membership follows from the pharmascold view of the world, in which financial conflicts of interest are uniquely dangerous and intrinsically immoral. It is these opposing worldviews, which are in part reflected in differences over conflict of interest, that are most at issue in the debate over academic–industry relationships. Thus, I take Brody to be mistaken in supposing that it is attacks on the concept of conflict of interest by pharmapologists that have sidetracked efforts to determine how medicine may productively but ethically engage with the pharmaceutical industry. Pharmascolds and pharmapologists simply disagree over what such engagement should look like—unsurprisingly, given their differing views of how we may best achieve productive innovation in medicine while preserving physician ethics.

REFERENCES