

THE ROLE OF INTELLECTUAL BELIEFS AND PROFESSIONAL CULTURE AS A SOURCE OF POTENTIAL CONFLICTS OF INTEREST

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ABSTRACT

This article explores the role of 'systems of beliefs' and disciplinary and professional norms and culture as a potential source of conflicts of interest in decision-making by professionals. In particular it argues that 'intellectual' views and professional values and agendas, may represent a potent source of potential conflicts of interest, which may not be readily recognised or fully understood across diverse disciplinary or professional settings, because of differing disciplinary/professional world-views, training and priorities. The article argues that there is a need for more open and honest cross-disciplinary conversations about how conflicts of interest are constructed and navigated in different scholarly and professional contexts. This is key to unmasking potential conflicts of interest that may unconsciously be sourced by particular intellectual views, positions and systems of beliefs, particularly when they are unquestioningly assumed to be beneficent. This discussion is important for decision-makers,

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such as university human research ethics committees and other cross-disciplinary institutional or organisational (corporate and non-corporate) decision-making or review bodies, for whom potential conflicts of interest are a core consideration in their activities and deliberations.

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I. INTRODUCTION

As Chair and member of an institutional Human Research Ethics Committee (HREC) I'm regularly provoked to think about potential conflicts of interest (COI) that might arise and impact on the research that is the subject of the HREC's review, as well as the potential COI that may arise in the ethical review process itself. An HREC is composed of a number of members from a wide range of professional, cultural and social backgrounds.² Some recent discussions around my HREC table have highlighted for me just how diverse committee members' understandings can be, of what constitutes a conflict of interest, and how potential COI may not even be considered relevant, due to a person's worldview or how they perceive and situate themselves politically, intellectually or professionally. Increasingly I have been alerted to how particular disciplinary backgrounds and professional training might influence people's assessment of whether a potential conflict of interest might be enlivened, its nature and its likely impact on decision-making. In particular, I have started to think about possible differences between the scientific and medical profession's conception of COI, and that of other disciplines and professions, such as the legal profession. And whether, such differences matter, and if so, how and why?

Against this backdrop, this article seeks to explore how COI are perceived, constructed and prioritised in different disciplinary and professional settings. This is an important discussion for institutional ethics committees and other similar boards and organisational bodies which are constituted by a diverse professional and lay membership (whether in a corporate, governmental or academic context) and whose core activities and decision-making involve identifying and thinking about the impact of potential conflicts of interest.

The purpose of this article is to highlight and remind us that potential COI may be interpreted and viewed in different ways by people from diverse backgrounds, and perhaps, that in certain settings, a more explicit discussion needs to occur around potential COI, so as to ensure that everyone is on the same page and that decisions are being made in an open and transparent way, and with common understanding. Sometimes, as decision-makers, we have to be prepared and equipped to more readily step outside our own worldview or professional lens, in order to honestly and genuinely engage with potential COI, and thereby avoid introducing unconscious bias and unfairness into our decisions, even if (and perhaps especially if) we are convinced that what we, or others are doing, is for the better 'good'.

II. WHAT IS THE CONFLICT OF INTEREST?

² Most institutional ethical review committees mandate inclusion of clinicians, lawyers, laypeople, pastors or spiritual leaders, and researchers.

As a point of departure we need to, at least generally, ask, what we understand as constituting a ‘conflict of interest’. COI (also referred to as ‘competing interests’, ‘dual commitments’, and ‘dual loyalties’) describe circumstances in which a primary interest (matters of professional judgment) may be at risk of undue influence by secondary interests.³ Alternatively, conflicts of interest can be framed as “a structure that carries an invitation”:

The structure is comprised of (1) a relationship featuring a strong obligation based on trust – for professions, a loyalty in which the provider places the beneficiary’s interests above his or her own interests, and (2) an opportunity to act contrary to that obligation. The invitation arises when such an opportunity is sufficiently attractive that it poses a significant temptation to override the obligation.⁴

The distinction between primary and secondary interests is drawn by separating the requirements and obligations of an entity’s (individual or group) particular professional activity or role (e.g. duties to clients and patients, conducting or reviewing research) from ‘external’ interests that are referable solely to their private benefit, involvement in other activities or their existing relationships.⁵ These secondary interests can broadly be categorised as either being “financial” or “nonfinancial” in nature.

Financial COI can take a myriad of forms and may include: research grants and contracts; consultancies; employment opportunities; positions on committees and boards; stock ownership or options; honoraria; intellectual property (including patents, royalties, and licensing fees); paid expert testimony; and participation in speakers’ bureaus or other professional forums or honours.

Non-financial COI (NFCOI) are more difficult to characterise. Most definitions of NFCOI describe such conflicts in the negative -encompassing all undue secondary interests that are not financial.⁶ The three most commonly identified NFCOI, which are of particular concern to this essay, relate to ‘systems of belief’, professional objectives, and

³ Pascal Probst et al., *Thirty Years of Disclosure of Conflict of Interest in Surgery Journals*, 157, SURGERY 627, 627 (2015); INTERNATIONAL COMMITTEE OF MEDICAL JOURNAL EDITORS (ICMJE), RECOMMENDATIONS FOR THE CONDUCT OF REPORTING, EDITING AND PUBLICATION OF SCHOLARLY WORK IN MEDICAL JOURNALS (2016); Bernard Lo & Marilyn J Field, *Conflict of Interest in Medical Research*, EDUCATION, AND PRACTICE (National Academies Press, 2009), <https://www.ncbi.nlm.nih.gov/books/NBK22942/>.

⁴ E Haavi Morreim, *Taking a Lesson from the Lawyers: Defining and Addressing Conflict of Interest*, 11 AMERICAN JOURNAL OF BIOETHICS 33 (2011).

⁵ Probst et al., *supra* at 627.

⁶ Richard S Saver, *Is It Really All About the Money? Reconsidering Non-Financial Interests in Medical Research*, 40 JOURNAL OF LAW, MEDICINE & ETHICS 467,468 (2012); Meera Viswanathan et al., *A Proposed Approach May Help Systematic Reviews Retain Needed Expertise While Minimizing Bias from Nonfinancial Conflicts of Interest*, 67 JOURNAL OF CLINICAL EPIDEMIOLOGY 1229, 1231 (2014).

personal relationships.⁷

Systems of belief, as a source of conflict, can be pervasive, encompassing intellectual, political, religious or professional beliefs, and may unwittingly result in bias in decision-making. ‘Intellectual’ COI refer to academic or scholarly “activities that create the potential for attachment to a specific point of view that could unduly influence an individual’s judgement about a specific”⁸ matter or recommendation. For researchers, it has been suggested that “preset beliefs in the likely outcome or a sincere conviction that a particular result is correct are more potent confounders of unbiased observation than financial interests” because of their potential to influence the entire research process, and especially the interpretation of evidence or data.⁹ Similarly, researchers may possess “ambition to advance ... knowledge, investigative zeal, and intellectual passion” that might “undermine investigator objectivity and subject protection”.¹⁰ Such ‘intellectual’ COI may arise in many other academic or professional contexts beyond that of the ‘researcher’. For example, it may apply to health or medical professionals involved in new cutting-edge therapies, lawyers pursuing justice for the disadvantaged or oppressed; indeed in any professional context where those involved may unquestioningly assume and pursue the beneficence of their activities. In the context of an institutional ethics committee or other similar review or organisational committee, the power of such intellectual COI may be amplified by the group membership and the collective force of the group’s convictions. Members of an HREC, for example, are often deeply committed and passionate about the ethical conduct of research. Their perception and strong belief in the beneficence of ethical review and the legitimacy of the ethical review process, creates a particular intellectual prism through which decisions are made. This may unconsciously obscure and entrench potential conflicts of interest around the table, and influence the committee’s deliberations and decision-making, perhaps through a strengthened collective conviction over time, as the group’s identity and ideological unity is fortified.

Professional objectives (which are not unnecessarily unrelated to ‘systems of beliefs’) may also be a source of potential conflicts of interest. These may cover a wide range of second-

⁷ ICMJE, supra at 3; Lo and Field, supra; Claire Johnson, *Conflict of Interest in Scientific Publications: A Historical Review and Update*, 33 JOURNAL OF MANIPULATIVE AND PHYSIOLOGICAL THERAPEUTICS 81 (2010); Ravi P Mahajan, *Conflicts of Interest in Medical Journals*, 41 COLOMBIAN JOURNAL OF ANESTHESIOLOGY 179 (2013).

⁸ David Lau, *Addressing Conflict of Interest and Bias in Research, Education and Clinical Practice*, 39 CANADIAN JOURNAL OF DIABETES 247, 248 (2015); Khaled Shawwa et al., *Requirements of Clinical Journals for Authors’ Disclosure of Financial and Non-Financial Conflicts of Interest: A Cross Sectional Study*, 11 PLoS ONE 1 (2016); Elie A Akl et al., *Considering Intellectual, in Addition to Financial, Conflicts of Interest Proved Important in a Clinical Practice Guideline: A Descriptive Study*, 67 JOURNAL OF CLINICAL EPIDEMIOLOGY 1222 (2014); see also Saver 2012, supra at 468, Viswanathan et al., supra at 1232.

⁹ Ross E McKinney Jr & Heather H Pierce, *Strategies for Addressing a Broader Definition of Conflicts of Interest*, 317 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1727, 1727 (2017).

¹⁰ Saver, supra at 468.

ary interests and motivations, including career advancement (both for tenure and promotion), and recognition from peers (including honours and prestige) which take on a particular significance or importance in a particular disciplinary or professional context.¹¹ Professional drivers and established indicia or ‘models’ of success within a professional group may be a strong influencing force and source of COI. Such may be imbued in professional identity and notions of professional ‘success’ right from the beginning of their university study and training and thereafter reinforced through professional milestones and culture.¹²

Likewise personal relationships with the potential to influence professional behaviours or judgments and decisions can source a conflict of interest.¹³ Relationships with institutions and other professional entities for example, may also have the potential to conflict with primary interests.¹⁴ One area of growing attention is the ever expanding development of partnerships between organisations and institutions with corporate sponsors and funders, and the potential impact of such in normalising the ‘demands of the market’ and ‘commercial interests’ at the institutional or organisational level and thereby perhaps obscuring potential COI.¹⁵

Such potential COI grounded in professional objectives, institutional or organisational membership and roles, and personal or professional relationships are relevant to decisions or ‘choices’ made by researchers and other professionals in their professional and related activities. They may also, for example, play out in the decisions of HREC’s and other similar committees or bodies that are charged with institutional or organisational related decisions. It may be difficult for such committees and bodies to readily appreciate how such specific potential conflicts of interest are manifesting for particular members, when the membership is varied, and to unpack these around the table. This is because some of these potential sources of COI may not be readily ‘visible’ or appreciated by all members who work outside the institution or organisation, or for those who have a different disciplinary or professional lens or focus, or are situated within a specific institutional or organisational quarter and are influenced by that particular (potentially insular) world view and understanding, and so are unable to identify even the need to interrogate the probity of such broader influences. Those within a particular profession on the other hand, may be blind to the impact of such influences on their own thinking and decision-making, because such influences may be so deeply entrenched in their own professional culture and

¹¹ Id. at 468; Viswanathan et al., *supra* at 1232.

¹² Cruess et al., *A Schematic Representation of the Professional Identity Formation and Socialization of Medical Students and Residents: A Guide for Medical Educators*, 90 *ACADEMIC MEDICINE* 718 (2015); Christine Cerniglia Brown, *Professional Identity Formation: Working Backwards to Move the Profession Forward*, 61 *LOYOLA LAW REVIEW* 313, 320 (2015).

¹³ Viswanathan et al., *supra* at 1232.

¹⁴ Arthur L Caplan, *Is Industry Money the Root of All Conflicts of Interest in Biomedical Research?*, 59 *ANNALS OF EMERGENCY MEDICINE* 87 (2012); Id. at 1232.

¹⁵ Christopher Mayes et al., *Conflicts of Interest in Neoliberal times: Perspectives of Australian Medical Students*, 25 *HEALTH SOCIOLOGY REVIEW* 256 (2016).

identity that they are simply not ever brought into question. Furthermore the dominance of particular disciplines or professionals in some professional settings or on committees or in boardrooms may further serve to silence ‘outsider’ or ‘marginal’ voices and render such potential conflicts of interest even more opaque; preventing them from being scrutinised and unmasked.

III. CONFLICTS OF INTEREST AND HUMAN RESEARCH

Codes on ethical conduct in human research generally explicitly address and eschew conflicts of interest. For example, the Australian National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research 2007 requires that institutions “establish transparent processes to identify and manage actual and potential conflicts of interest involving: a. the institution itself; b. researchers; or c. ethical review bodies, their members or advisors.”¹⁶ Statements of this kind address the vital policy objective of building public trust in the human research ethical review process which as a broad-based objective, includes four specific goals:

1. To protect the rights and welfare of human participants;
2. To promote social justice, especially in ensuring equitable subject selection and a fair distribution of the benefits and burdens of research;
3. To produce results that benefit society, especially in public health research;
4. To foster public trust in both the methods and results of research, in order to ensure funding and the recruitment of future subjects.¹⁷

If the full spectrum of potential COI are not recognised and carefully considered in ethical or other like review processes, they can impact and indeed compromise not only research processes but the ethical or other review processes themselves, and ultimately such important public policy interests and objectives. Potential conflicts of interest can impact every stage of research from the choice of research topic (“to choose a topic of research that has the potential for better funding or other financial benefits”), study design, data analysis and interpretation, through to data reporting and dissemination of findings.¹⁸

While many consequences of COI on research may be unintended or even perhaps unconscious, the pursuit of secondary interests, to the detriment of research integrity, has been observed and is well recorded. Berger, for example, refers to ‘selective inertia’ (“an unnatural selection of research methods based on which are most likely to establish the preferred conclusions, rather than on which are most valid”) as a mechanism through

¹⁶ Section 5.4.1.

¹⁷ David B Resnik, *Public Trust as a Policy Goal for Research with Human Subjects*, 10 AMERICAN JOURNAL OF BIOETHICS 15, 16 (2010).

¹⁸ Lindsay Hampson & James Montie, *Conflict of Interest in Urology*, 187 JOURNAL OF UROLOGY 1971, 1974.

which researchers can consciously sway their research results in a biased or flawed way.¹⁹ Other research has discovered active efforts on the part of researchers to alter or suppress data. For example, Martinson et al. and Carragee et al. reported that industry influence or funding led to pressure to suppress or underreport negative data.²⁰ Additionally, Martinson et al. in a 2005 US federally-sponsored survey of 3,000 academic scientists, found that 15% of them admitted to altering study design or results based on pressure stemming from an external funding source. Conversely, it has been suggested that perhaps “the disclosure of conflicts of interest may exacerbate biases in the presentation of research by creating the impetus to compensate for the disclosure”²¹ creating a reverse bias in presentation of findings against sponsor interest. Either way, such COI are potentially biasing research processes and its outcomes.

A. A Medical Research

The pre-eminence of considerations of COI in medical research has been primarily connected to the growing dependence of research on the financial contributions of industry (see, e.g., Brody, 2011), whether directly from a corporation itself or through organisations and government agencies that work with industry to promote particular devices or pharmaceuticals.²² References to a “medical-industrial complex” date back to the 1980s; and it has been suggested that presence of an industry sponsor (especially one whose medical intervention is the subject of the research) is “the factor most likely to exert an inappropriate influence on investigator professionalism”.²³ Strikingly today, two-thirds of biomedical research globally is supported by industry. Studies have also begun to investigate suggestions that the larger the size of financial incentives, the greater the COI concerns.²⁴

Moreover, the ability to conduct human research in medical fields relies on the ability to source research subjects (often in large samples). However, in the field of pharmaceutical

¹⁹ Vance W Berger, *Conflicts of Interest, Selective Inertia, and Research Malpractice in Randomized Clinical Trials: An Unholy Trinity*, 21 SCIENCE AND ENGINEERING ETHICS 857, 857 (2015).

²⁰ Brian Martinson et al., *Scientists Behaving Badly*, 435 NATURE 737 (2005); Eugene Carragee et al., *A Critical Review of Recombinant Human Bone Morphogenetic Protein-2 Trials in Spinal Surgery: Emerging Safety Concerns and Lessons Learned*, 11 THE SPINE JOURNAL 471 (2011).

²¹ AG Dunn et al., *Conflict of Interest Disclosure in Biomedical Research: A Review of Current Practices, Biases, and the Role of Public Registries in Improving Transparency*, 1 RESEARCH INTEGRITY AND PEER REVIEW 1, 2 (2016).

²² J Diels et al., *Association of Financial or Professional Conflict of Interest to Research Outcomes on Health Risks or Nutritional Assessment Studies of Genetically Modified Products*, 36 FOOD POLICY 197, 198 (2011).

²³ Probst et al., *supra* at 627; Dunn et al., *supra* at 1.

²⁴ Justin Chakma et al., *Asia's Ascent – Global Trends in Biomedical R&D Expenditures*, 370, NEW ENGLAND JOURNAL OF MEDICINE 3, 3-6 (2014); see Bernard Lo & Deborah Grady, *Payments to Physicians: Does the Amount of Money Make a Difference?*, 317 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1719 (2017).

development in particular, there has been increasing demand and competition for subjects due to “the spectacular increase in research activity over the last two decades, an increase in large part driven by growing commercial interests in research”.²⁵ This is an area which has become rife with the influence of FCOIs. To attract referrals, industry engages in practices such as offering substantial payments to researchers and clinicians for referrals, invitations to make well-paid presentations of research findings or to participate in prestigious seminars, the appointment of researchers to lucrative positions on sponsors’ scientific advisory boards and specialised committees, and paid consulting relationships.²⁶ In some industry-sponsored trials, there have even been reports of companies determining the authorship of study results on the basis of physicians’ patient enrolment figures.²⁷

In the US, the seeming ubiquity of this issue in the medical profession has even produced legislative intervention specifically targeting the profession and its industrial affiliates. The *Physical Payments Sunshine Act (PPSA)*, signed into law in 2010 as part of the *Patient Protection and Affordable Care Act*, requires pharmaceutical, medical device, biological, and medical supply manufacturers to report to the Department of Health and Human Services any payments to physicians and teaching hospitals that exceed US\$10; the payments are then made a matter of public record via a database.²⁸ Proposals have also been made to devise methods for operationalising FCOIs, especially in the scientific and medical communities, including through “FCOI scales” that express the nature and extent of FCOIs on research, with a numerical score correlating to descriptive terms for potential biases and sample conflicts.²⁹

The presence of COIs in human research, especially FCOIs, may exert an influence over the process and results of the research. This influence may be subtle; researchers “might become more lenient with respect to informed consent procedures, they may convince themselves that research participation is in their patient’s best interests, or they may be overly flexible with regard to the study inclusion and exclusion criteria”.³⁰ In more measurable terms, there have been extensive academic attempts to measure the potential influence of COI on the results of medical and dental research (predominant clinical trials)

²⁵ TRUDO LEMMENS & PAUL B MILLER, THE HUMAN SUBJECTS TRADE: ETHICAL, LEGAL, AND REGULATORY REMEDIES TO DEAL WITH RECRUITMENT INCENTIVES AND TO PROTECT SCIENTIFIC INTEGRITY LAW AND ETHICS IN BIOMEDICAL RESEARCH, 135-136 (Trudo Lemmens & Duff Waring, 2017).

²⁶ Id. at 135.

²⁷ Id. at 141.

²⁸ For further background, see Susan Chimonas, Frederica Stahl & David J Rothman, *Exposing Conflicts of Interest in Psychiatry: Does Transparency Matter?*, 35 INTERNATIONAL JOURNAL OF LAW AND PSYCHIATRY 490 (2012); Susan L Norris et al., *Characteristics of Physicians Receiving Large Payments from Pharmaceutical Companies and the Accuracy of Their Disclosures in Publications: An Observational Study*, 13 BMC MEDICAL ETHICS 24, 25 (2012).

²⁹ S V M Maharaj, *A New Method for Scoring Financial Conflicts of Interest*, 21(1) INTERNATIONAL JOURNAL OF OCCUPATIONAL AND ENVIRONMENTAL HEALTH 49 (2015).

³⁰ Supra at 139.

involving human subjects. The overwhelming, but not universal, consensus appears to be that the presence of COI, whether financial or non-financial and whether disclosed or not disclosed, are linked with the particular outcomes being measured.³¹

B. Non-medical Research

Despite a dominance of research into COI related to medical and health research, COI concerns have arisen, and are increasingly being discussed also in other disciplinary contexts. In the humanities and social sciences, research involving community-based participation can be affected by ‘partnership tensions’, both as a financial and nonfinancial source of conflict. Just as industry sponsors may have an influence on study design for medical studies, pressure from institutional partners may result, for example, in the expulsion of particular community participants in order to ensure the ‘success’ of the research:

Given the centrality of community participation to CBPR, deliberate expulsion and exclusion of community participants would not be a decision taken lightly and might be influenced by the researcher’s perception of risk of non-compliance (with requirements of funding bodies, universities, service providers or government). We highlight the ethical challenge for researchers faced with institutional conflicts of interest who make the decision to exclude community members from CBPR for ‘institutional self-protection’. To remain faithful to the emancipatory empowering paradigm would mean to avoid falling back on traditional conceptions of research and tokenistic participation when principles of CBPR, including community empowerment, threaten research success. Silencing can itself be detrimental to research results and interventions by missing the “authentic community voice”.³²

Other potential conflicts of interest may arise when professionals assume multiple roles in ‘social’ based research, for example, increasingly in higher education settings we see ‘teachers’ also engaged as ‘pedagogical researchers’. A conflict may arise when the teacher wishes to use student-learning data, involve students as participants in their research, or

³¹ E.g. Lotte E van Nierop et al., *Source of Funding in Experimental Studies of Mobile Phone Use on Health: Update of Systematic Review*, 11 *COMPTES RENDUS PHYSIQUE* 622 (2010); Diels et al., *supra*; Tatiana Lerner et al., *The Prevalence and Influence of Self-Reported Conflicts of Interest by Editorial Authors of Phase III Cancer Trials*, 33 *CONTEMPORARY CLINICAL TRIALS* 1019 (2012); Haris Riaz et al., *Conflicts of Interest and Outcomes of Cardiovascular Trials*, 117 *AMERICAN JOURNAL OF CARDIOLOGY* 858 (2016); Andreas Lundh et al., *INDUSTRY SPONSORSHIP AND RESEARCH OUTCOME* (Report, 2017); Elton Leite et al., *Trial Sponsorship and Self-Reported Conflicts of Interest in Breast Cancer Radiation Therapy: An Analysis of Prospective Clinical Trials*, 33 *THE BREAST* 29 (2017).

³² Community Based Participatory Research (CBPR) is generally understood as a collaborative approach to research that equitably involves all partners in the research process and in shared decision-making, in recognition of partner expertise and the unique strengths of each partner, see Elena Wilson, Amanda Kenny & Virginia Dickson-Swift, *Ethical Challenges of Community Based Participatory Research: Exploring Researchers’ Experience*, *INTERNATIONAL JOURNAL OF SOCIAL RESEARCH METHODOLOGY* 1 (2017) doi: 10.1080/13645579.2017.1296714.

perhaps also other teaching staff.³³ Another example is provided by Lunt and Fouché, who note the potential conflict when social workers assume the dual roles of ‘social worker practitioner’ and ‘practitioner researcher’.³⁴ This conflict materialises when the social worker wishes to undertake their own research and the primary respondents will be clients or staff, thereby affecting the practitioner’s relationships. These types of COI may pose a challenge to duty of care issues in relation to clients or students, while separate challenges will arise in relation to the reporting of results and proper acknowledgement of colleagues’ contributions. It may also affect clients’, students’ and colleagues’ ability or willingness to exercise their right not to participate in (or to withdraw from) the research without fear of negative consequences. Institutions will usually have ethical rules in place to protect potential research subjects, but ‘probing research interests’, particularly where vulnerable or ‘dependent’ individuals are involved, may tempt researchers to breach their responsibility and do “more-than-least harm” to their subjects.³⁵

This discussion so far has highlighted that research grounded in different disciplinary spheres may give rise to certain disciplinary specific potential conflicts of interest which may not translate to or equally prevail within other research fields or which may assume a different form and with different impact. Accordingly researchers working within different fields of research may not appreciate the full context and culture of potential conflicts of interest in other fields or may, based on their own disciplinary context and experience, misconstrue or misunderstand the ecology that may source potential conflicts of interest in other fields and contexts. This points to the imperative for open, ongoing, reflective and honest conversations across disciplinary lines to promote mutual understanding of such potential conflicts of interest in different research fields and contexts, and thereby enabling such to be interrogated as necessary to avoid the potential bias that might otherwise arise.

IV. CONFLICTS OF INTEREST IN PROFESSIONAL CONTEXTS

In this next part of the article I look at the nature of COI in two specific professional contexts – first, the medical professional setting and secondly, within the legal profession. The purpose of this discussion is to highlight potential differences in the way COI manifest within these different professional contexts and, by analogy, in other professional contexts as well. This discussion builds on the first part of the paper to show that different

³³ Albert F G Leentjens & James L Levenson, *Ethical Issues Concerning the Recruitment of University Students as Research Subjects*, 75 JOURNAL OF PSYCHOSOMATIC RESEARCH 394 (2013); Shirley K Comer, *The Ethics of Conducting Educational Research on Your Own Students*, 13 JOURNAL OF NURSING LAW 100 (2009); Emily M Bartholomay & Sarah K Sifers, *Student Perception of Pressure in Faculty-Led Research*, 50 LEARNING AND INDIVIDUAL DIFFERENCES 302 (2016).

³⁴ Neil Lunt & Christa Fouché, *Practitioner Research, Ethics and Research Governance*, 4 ETHICS AND SOCIAL WELFARE 219, 227-228 (2010).

³⁵ Nadia von Benzon & Lorraine van Blerk, *Research Relationships and Responsibilities: “Doing” Research with “Vulnerable” Participants*, SOCIAL & CULTURAL GEOGRAPHY 7 (2017) doi: 10.1080/14649365.2017.1346199.

disciplinary and professional contexts source different types of conflicts of interest that are potentially perceived and understood through quite different lenses depending on a person's intellectual and professional position and training. Accordingly it will infer that these differences influence the systems of belief and constructs that varied professionals utilise and draw on, when they are called to consider potential conflicts of interest outside their specific professional practice or setting.

B. Non-medical Research

For medical professionals,

[t]he primary professional interest of each physician should be “to care for and protect the interests and wellbeing of patients to the best of that physician’s abilities, while making sure her or his abilities are maintained as new discoveries are made.”³⁶ Physicians assume a variety of roles as they pursue this primary interest, for example, patient care, research and innovation, education, guideline development, public and population health, administration, policy formulation, or advocacy. Each of these roles brings with it specific personal secondary interests, such as competition for patients and trainees, extramural research funding, or high-profile publications, and financial compensation. External relationships with for-profit businesses create additional secondary interests, for example, honorarium, royalties, equity, and sponsorship.³⁷

It is clear that COI can variously manifest in the work of a medical professional and in the context of medical practice. However, there are two broad obligations and responsibilities for the medical professional that I will focus on which may often give rise to potential COI - ensuring patient care, and formulating clinical practice guidelines.

1. Anti-corruption campaign

Patients “rely on the independence and trustworthiness of doctors for any advice or treatment offered”.³⁸ There is a fiduciary relationship between doctors and their patients, and the presence of COI could influence the practitioner to make decisions which adversely impact on patient well-being and outcomes, wastefully increase health care costs, or otherwise contribute to a loss of trust in the health care system.³⁹

³⁶ William W Stead, *The Complex and Multifaceted Aspects of Conflicts of Interest*, 317 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1765 (2017) citing Catherine D DeAngelis, *Medical Professionalism*, 313 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1837 (2015).

³⁷ Stead, *supra* at 1765.

³⁸ Medical Board of Australia, *GOOD MEDICAL PRACTICE: A CODE OF CONDUCT FOR DOCTORS IN AUSTRALIA* 21 (Mar., 2014), <http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>.

³⁹ Christopher Robertson, Susannah Rose & Aaron S Kesselheim, *Effect of Financial Relationships on the Behaviour of Health Care Professionals: A Review of the Evidence*, 3 THE JOURNAL OF LAW, MEDICINE AND ETHICS 452 (2012).

One well-known source of COI for medical practitioners is links with the pharmaceutical industry, which invests billions annually on strategies to influence practitioners' prescription patterns.⁴⁰ Such strategies include gift-giving, free samples, funding for conference travel, funding for conference presentations and continuing education programs, honoraria, and marketing in both medical journals and the lay press. It is not only practising physicians, but also trainees, which are the subject of these overtures from industry.⁴¹ The risk for patient care arises when the drug or device being prescribed is either expensive and ineffective, or (at worst) unsafe, resulting in the provision of care that is neither economically efficient nor in the patient's best interests.⁴² Similarly, in some jurisdictions such as in the US, different fee structures for treating physicians, as well as the availability of self-referral to physician-owned or -affiliated businesses, can also result in the recommendation of unnecessary and expensive treatment for the patient.

In addition to the previously discussed human research dimension, medical practitioners' involvement in encouraging and facilitating patient participation in human research, where patients may be subjected to unproven and potentially dangerous therapies, is a prominent COI issue. The practitioner's interest is in fulfilling publication requirements, clinical service development by obtaining access to new technology prior to competitor hospitals, and research program development by generating the income associated with study conduct.⁴³ However, in the US and Canada, these secondary interests have led practitioners to "[engage] in excessive 'enrolment activities' in exchange for money ... [including] perpetrated fraud, falsifying their recruitment records in order to increase their profits. Others ignored exclusion criteria designed to ensure the safety of subjects and the validity of research results, referring their patients to research investigating treatments for conditions from which they did not suffer".⁴⁴ In such cases of wilful disregard for patient health and safety, the practitioners' breach of their obligations to ensure their patients receive the proper care is particularly egregious:

The vulnerability of a doctor's own patients to become an experimental research subject because of their trust in their doctor, combined with the signing bonuses which the doctor pockets for the referral, sets up a toxic situation where some

⁴⁰ Neena Chappell et al., *Conflict of Interest in Pharmaceutical Policy Research: An Example from Canada*, 21 INTERNATIONAL JOURNAL OF HEALTH GOVERNANCE 66, 69 (2016); Moses Hamilton III et al., *The Anatomy of Medical Research: US and International Comparisons* 313 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 174 (2015).

⁴¹ Marissa King & Peter S Bearman, *Gifts and Influence: Conflicts of Interest Policies and Prescribing of Psychotropic Medications in the United States*, 172 SOCIAL SCIENCE & MEDICINE 153 (2017); Chappell et al, supra at 69 (2016); Id. at 45; Hampson & Montie, supra.

⁴² Robertson, supra.

⁴³ Aine Donovan & Aaron V Kaplan, *Navigating Conflicts of Interest for the Medical Device Entrepreneur*, 55 PROGRESS IN CARDIOVASCULAR DISEASES 316, 318 (2012).

⁴⁴ Lemmens & Miller, supra at 132.

doctors are literally selling their own patients into human experiments.⁴⁵

Lemmens and Miller noted another corollary of conflict between practitioners' financial interests and those of their patients in receiving timely medical care.

Particularly when access to care is scarce and waiting lists are significant, finder's fees can greatly exacerbate access issues, overburdening those physicians who have chosen not to spend a large proportion of their time recruiting patients and filling out forms against considerable payment. The phenomenon raises justice concerns, both insofar as the financial interests hamper patient access to care, and insofar as the burdens of providing that care may become unequally distributed among members of the profession.

[...]

When waiting lists for treatment are long, the prospect of participation in research often becomes a tempting route to care for anxious patients. Physicians involved in remunerative recruitment may be tempted to suggest to patients that research participation will give them faster access to care. In such circumstances, one of the core principles of research ethics is compromised – namely, that which requires research subjects' consent to participation to be free from undue influence or coercion.

However, studies into the attitudes of patients and the general public towards practitioners' COIs do not support the position that they universally, or even mostly, consider practitioners' COI unethical or unfavourable. DiPaola et al. (2014), Yi et al. (2015), and Yi et al. (2016) all found that participants were largely unconcerned about connections with industry, provided that the practitioner disclosed the conflict to his or her patients; in other words, participants considered disclosure the most important means of self-regulation and COI management.⁴⁶ Would the public or clients of other professional services take a similar view to such conflicts of interest that arise in other professional contexts, outside the medical profession? Or do public perceptions about doctors' COI of themselves point to an inherent imbalance in how society views medical professionals and the status doctors are accorded, which perhaps evidence a source of potential COI in societal relationships with doctors, worthy of greater recognition and recourse?

2. Clinical Practice Guidelines

⁴⁵ Id. at 138, citing U.S., National Institutes of Health, *Conference on Human Subject Protection and Financial Conflicts of Interest* (conference transcript) 45 (2000).

⁴⁶ Christian P DiPaola et al., *Surgeon-Industry Conflict of Interest: Survey of North Americans' Opinions Regarding Surgeons Consulting with Industry* 14 *THE SPINE JOURNAL* 584 (2014); Paul H Yi et al., *Are Financial Conflicts of Interest for the Surgeon a Source of Concern for the Patient?*, *JOURNAL OF ARTHROPLASTY* 21(2015); Paul H Yi et al., *Patient Attitudes Toward Orthopedic Surgeon Ownership of Related Ancillary Businesses* 31 *JOURNAL OF ARTHROPLASTY* 1635 (2016).

The Institute of Medicine defines clinical practice guidelines as “systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances”.⁴⁷ Such guidelines “are considered one of the most important services that medical societies provide. Guidelines serve a unique role to standardize care, define quality of care, and are used in malpractice cases”.⁴⁸

In the development of clinical practice guidelines, the influence of the intellectual COI of committee experts who work on the guidelines have been touted; however, industry also helps to define new diseases and determine ‘best practices’ for treating them, usually through their connections with the deciding experts.⁴⁹ Various studies have been conducted on the frequency of COI whether financial or nonfinancial, disclosed or undisclosed, amongst those on the relevant committees.⁵⁰ This research underscores that there is a strong connection between experts in medical fields highlighting that “[t]he lack of disclosure of COI raises significant issues regarding the transparency and validity of the guideline development process”⁵¹ ... and more generally emphasises that “transparency regarding any untold influences is critical”.⁵²

B. Non-medical Research

The legal profession has arguably adopted a more clearly defined view of what constitutes a conflict of interest than has the medical profession. There is seemingly less interest in the legal professional context in distinguishing between different types of COI. This can generally be seen in the way that conflicts of interest are described and characterised in legal professional conduct rules and other legal professional statements across many jurisdictions.

Conflicts between the interests of clients, whether current or former, may prevent a lawyer from acting for one of the parties. In the case of former clients, this proscription against acting for a client in conflict with a former client’s interests is mostly concerned

⁴⁷ Lo and Field, *supra*.

⁴⁸ Joseph D Feuerstein et al., *Systematic Analysis of the Quality of the Scientific Evidence and Conflicts of Interest in Osteoarthritis of the Hip and Knee Practice Guidelines*, 45 SEMINARS IN ARTHRITIS AND RHEUMATISM 379, 382 (2016); see also Lisa Cosgrove et al., *Conflict of Interest Policies and Industry Relationships of Guideline Development Group Members: A Cross-Sectional Study of Clinical Practice Guidelines for Depression*, 24 ACCOUNTABILITY IN RESEARCH 99 (2017).

⁴⁹ Chappell et al., *supra* at 69; Akl *supra*.

⁵⁰ Susan L Norris et al., *Authors’ Specialty and Conflicts of Interest Contribute to Conflicting Guidelines for Screening Mammography*, 65 JOURNAL OF CLINICAL EPIDEMIOLOGY 725, 731 (2012); Feuerstein et al., *supra*; Cosgrove et al., *supra*.

⁵¹ Feuerstein et al., *supra* at 384.

⁵² Chappell et al., *supra* at 69; Akl *supra*.

with protecting their confidentiality, rather than constituting a continuing conflict of interest.⁵³ In large firms, where the former and current clients whose interests are in conflict are represented by different lawyers, ‘information barriers’ have been devised as an imperfect solution to quarantine information and prevent the former client’s confidentiality from being compromised.⁵⁴

Beyond these client-centric categories, lawyers have also long been recognised as having duties to the profession and society more broadly.⁵⁵ However, where these duties conflict with clients’ interests, “appeals to one or more of these values can often be used to justify the violation of another”; specifically, “the importance of client confidentiality, attorney-client privilege, adherence to the wishes of their client, and the norm of zealous advocacy” may be used to override the laws of ethics.⁵⁶

It has been suggested that legal professionals owe a higher duty of loyalty, including greater duties of avoidance and disclosure, than other professional groups. Theories have been proposed as to why this is appropriate; writing in the context of the modern American legal system, Witkin wrote:

While doctors are entrusted with their patients’ lives and psychologists are entrusted with their clients’ deepest secrets, legal professionals are unique in that they assist one individual who is faced with the collective power of society embodied in the state. The clash between individual rights and such social regulation forges a unique relationship between legal professional and client. Serving one person against the collective whole demands a key virtue from legal professionals: loyalty. ... [W]orking in a system of rules that bind and potentially coerce the client demands an elevated duty of loyalty from the professional.

[...]

[A] system of binding laws poses a variety of practical reasons for its experts to promise undivided loyalty to clients. First, people with legal problems may act less on their understanding of the complicated structure of laws and procedures and more on a sense of fairness that is enhanced through the guidance of a loyal advocate. Next, experts in law represent individuals against adverse interests in society and must thereby address morally ambiguous situations. The simple ethic of loyalty to clients thereby allows legal experts to navigate these subjective dilemmas, provide uniform representation as part of a fair and balanced system, and rely on the adversarial court system to sort out truth and justice. Finally, the

⁵³ YSAIAH ROSS & PETER MACFARLANE, *ETHICS, PROFESSIONAL RESPONSIBILITY AND LEGAL PRACTICE* 346 (2017).

⁵⁴ *Id.* at 357.

⁵⁵ Nathan Witkin, *Dependent Advocacy: Alternatives to Independence between Attorneys*, 32 *OHIO STATE JOURNAL ON DISPUTE RESOLUTION* III, 124 (2017).

⁵⁶ Jennifer K Robbennolt, *Behavioural Ethics Meets Legal Ethics*, 11 *ANNUAL REVIEW OF LAW AND SOCIAL SCIENCE* 75, 78 (2015).

promise of loyalty promotes the use and quality of legal services. While the same could be said for any service or business, the promise of loyalty is especially important in the context of binding legal systems because clients may be mistrustful of legal experts who work within a system that may exert coercive force over the client.⁵⁷

There have been suggestions that the medical profession could (and should) adopt the legal profession's stricter approach towards outlining and proscribing certain COI. Specifically, this would involve recognising the "fundamental ethical principle" of loyalty and trust between practitioner and patient, and requiring both disclosure and the acquisition of informed consent before the practitioner is permitted to pursue the conflicting interest:

Attorneys' focused conversations about conflict are a far cry from the "disclosures" we find in health care. An oblique reference in a consent form for treatment or research may say "Dr. X's research is funded by Company Y," or "Dr. A is part owner of this facility and you are free to use the facility of your choice," or "As a prospective patient of Y Medical Center, we are pleased to inform you that this hospital is partly owned by physicians." The patient is virtually never told that the ownership represents a conflict of interest, or that the conflict directly threatens his or her interests. Neither is he or she asked to provide a special consent expressly for the conflict of interest.⁵⁸

At the very least this discussion has highlighted that medical and legal professional ethics and duties construct conflicts of interest in ways that give rise to points of divergence. This suggests that perhaps medical professionals will view potential conflicts of interest in different terms than lawyers; so then, when lawyers and doctors/clinicians are brought together on cross-disciplinary committees or boards and asked to make decisions that require consideration of conflicts of interest there is a real likelihood that they will do so from distinctly different points of reference. The implications of this needs careful consideration particularly when one professional voice is likely to dominate or mute the other due to unequal representation or influence in any given context. This applies equally to other professional groups represented on institutional and organisational cross-disciplinary and professional committees and boards.

V. POLITICAL CULTURE DIFFERENCE

Conflicts of interest may take a myriad of forms with far reaching potential to impact on

⁵⁷ Witkin, *supra* at 119–20.

⁵⁸ Morreim, *supra* at 34.

professionally related decision-making. This article has highlighted that even highly qualified professionals trained in ethical decision-making and bound by professional ethical guidelines and frameworks, may not fully recognise the impact of potential conflicts of interest in their activities, particularly when such activities involve decision-making outside the confines of their actual professional practice or specific disciplinary context e.g. clinicians or legal practitioners who are engaged on institutional ethics committees or other organisational committees or boards may unwittingly harbour professional biases in their decisions.

The article has argued that conflicts of interest may indeed be rendered invisible by entrenched professional or disciplinary values and cultures that unquestionably accept the benevolence and status of a profession, its activities and ethics. Such conflicts of interests are arguably further rendered immune to identification and interrogation, as often those outside particular professional or disciplinary circles will not understand the nature of professional relationships, drivers, incentives and identity. Whilst the value of cross-disciplinary and professional committees, panels and boards is obvious, the potential for conflicts of interest to unconsciously influence decisions of such entities may be less apparent and needs to be vented. The very constituency and perhaps mosaic homogeneity and heterogeneity in the character of such groups, may perhaps perversely mask potential conflicts of interest and unwittingly reinforce bias in important decision-making, and thereby ironically be doing so under the guise of promoting ethical decision making and ethical practices.