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Clarifying the costs of conflicts of interest

Peer-reviewed letter

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To the Editor

In response to Barton, Stossel and Stell's critique of conflicts of interest

Over the past two decades, a deep suspicion has emerged in the healthcare community about the influence of private industry – particularly the pharmaceutical industry – over doctors, researchers, regulators and policymakers [1, 2]. In response to the perceived threats posed by conflicts of interest (COI), there have been calls for a range of measures including stricter disclosure statements, more transparency, and tighter regulation of medical and industry interactions [3].

Not surprisingly, such demands tend to be resisted by the pharmaceutical industry, and by a subset of clinicians and researchers who believe that claims of adverse industry influence are overblown [4]. One such example is the recent article by Barton, Stossel and Stell in the *International Journal of Clinical Practice* [5].

Barton et al. argue that concerns about COI are exaggerated and unsupported by empirical evidence, and that demands for regulation and transparency distract medical professionals, researchers and policymakers from their primary task – improving patient outcomes. Furthermore, they suggest that if there is no evidence that patient outcomes are negatively affected by COI, then there is no cause for concern. They claim that the 'conflict of interest movement has failed to substantiate its central claim that interactions between physicians, researchers and the medical products industry cause physicians to make clinical decisions that are adverse to the best interests of their patients.' The medical community and bioethicists in particular, should therefore stop worrying about COI.

This is not a new argument. Indeed, the authors have been making this case for almost a decade [6], and others have made similar claims [7]. Despite the persistence of such arguments, there are two reasons to think that Barton and colleagues are mistaken: the first is that there are, in fact, reports that demonstrate that interactions with industry do in fact impede rational prescribing and may, therefore, harm patients [8-11]. The second and less obvious reason has to do with the way Barton et al. have defined conflict of interest.

According to Barton et al., the only grounds for concern about COI is negative patient outcomes – which, they suggest are ‘the only outcomes that really matter’ [5]. We suggest that this definition is inappropriately narrow and that by defining COI in this way, Barton et al. manipulate the debate and construct what is known as a ‘persuasive definition’ of COI. Coined by philosopher Charles Stevenson, a persuasive definition is a rhetorical tactic that purports to outline the standard meaning of a term, yet actually offers an idiosyncratic definition that redirects people's attitudes towards particular ends ([12], p. 210ff). Thus, while Barton et al. claim that their definition of COI reflects the concerns of those in the ‘COI movement’ it actually excludes much, and directs attention only towards the narrow issue of patient outcomes.

This strategy becomes clear when one considers how Dennis Thompson, the explicit target of Barton et al., defined COI as ‘a set of conditions in which professional judgment concerning a primary interest (such as a patient's welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain)’ ([13], p. 573). Thompson's definition is concerned with patient outcomes, but not exclusively so.

Thompson's definition reflects the reality that determining the interests of medical professionals is not straightforward [14, 15]. Medical professionals, especially those working in teaching and research hospitals, have many interests and roles. To suggest that medical professionals are exclusively occupied with the interests of patients is an idealized caricature. The plurality of roles and interests implies two things. First, there will be competition and conflict among interests (not necessarily bad). Second, patient outcomes are not the only area that can be negatively affected by COI [9, 16-21].

The so-called ‘COI movement’ uses a definition of COI similar to Thompson's. But rather than addressing the arguments and definitions of those they are criticising, Barton et al.'s use of a persuasive definition narrows the scope of COI such that the diverse concerns about COI can be dismissed as ‘ideological’ [5].

Barton and colleagues are, however, right to suggest that critical questions need to be asked about the significance of COI. But this will require more research about the meaning and impact of COI in medicine, not less.

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