Peeling the onion: Is more conflict of interest disclosure getting us closer to the truth?

New York, NY – The debate over just how individuals, institutions, professional societies, and scientific publications should divulge potential conflicts of interest (COI)—and indeed just what constitutes a conflict—has reached a fever pitch in recent months and shows no sign of abating.

Witness the brouhaha at the *Journal of the American Medical Association* (*JAMA*), where journal editors—noisy proponents of full COI disclosure—are now scrambling to downplay a new policy requesting that anyone concerned about a *JAMA* author's undisclosed COI keep mum about it until the journal can investigate [1]. This after neuroanatomy professor **Dr Jonathan Leo** (Lincoln Memorial University, Harrogate, TN) took his complaint about a *JAMA* author's undisclosed COI to *BMJ* when *JAMA* took too long to act [2].

For the first time at this year's **American College of Cardiology** (ACC) meeting, attendees surfing for swag in the exhibition hall were crestfallen to learn that logoed pens, Post-its, and tchotchkes are no more—targets of new guidelines from both the **Pharmaceutical Research and Manufacturers of America** (PhRMA) and device-industry group **AdvaMED** prohibiting distribution of "noneducational" products to doctors and staff. Elsewhere, academic institutions are ramping up restrictions on the kinds of freebies its doctors can accept from industry —Johns Hopkins recently announced that its staff could no longer accept drug samples or participate in consulting work. Others, such as the Duke Clinical Research Institute and the Cleveland Clinic, have adopted public COI-disclosure websites, ranging from voluntary to mandatory. Over at Big Pharma, Eli Lilly, Merck, and Pfizer have said they will start publicly disclosing payments made to physicians—a move that anticipates the federal **Physician Payment Sunshine Act**. Also making headlines this year, **Dr Sanjay Kaul** (Cedars Sinai Medical Center, Los Angeles, CA) was dropped from an **FDA** advisory panel hearing for prasugrel, not because of financial interests, but due to so-called "intellectual" conflicts.

Physician Payment Sunshine Act

US **Sens Chuck Grassley** (R-IA) and **Herb Kohl** (D-WI) introduced the Physician Payment Sunshine Act in January of this year. Beginning in 2010—if passed—the bill, which is similar to one introduced but never passed in 2007, would require drug and device companies to disclose all payments to physicians over $100 dollars in any calendar year, with that information available to the public, beginning in the fall of 2011.

But each fresh attempt toward more transparency seems only to usher in a fresh round of finger pointing and hand wringing. At one end of the spectrum are those who believe that academic leaders, heads of professional medical societies, and chairs of guideline writing committees should have absolutely no ties to industry dollars. On the other are those who point out that in any given medical specialization, the people who know the most about a disease, therapy, or technique will in many cases be the same ones who have gone on to devise the best treatments or at least provide the smarts to companies making products that help save lives in their

particular area of specialization.

If you admit you work with industry, it's like you're somehow automatically a bad person.

"The risk of being accused of *not* doing things right is significant, and it's especially bad right now in academic centers, where, if you admit you work with industry, it's like you're somehow automatically a bad person," **Dr Robert Califf** (Duke Clinical Research Institute, Durham, NC) told **heart*wire***. "But we all know that we need medical products: drugs and devices account for a lot of the improvements in health, and we need them to be good."

Dr Robert Califf

As a result, physicians and researchers are increasingly worried about doing the right thing, or at least appearing to do so.

"I think it's a challenge to the whole system because the people who are often the most knowledgeable about a specific drug or device are those who are involved with industry in researching that drug or device," **Dr Glenn N Levine** (Baylor College of Medicine, Houston, TX) told **heart*wire***. He points to two factors feeding public and professional distrust over the COI-disclosure process. One is the media attention surrounding physicians "outed" for not disclosing all of their actual or potential conflicts. The other is a wider awareness within the medical community of specific individuals or groups who blithely fail to mention relationships that their peers know or believe to exist. The result, says Levine, is that people "have become more and more suspicious about whether people are actually disclosing their relationships."

The steep costs of doing business

Dr Doug Weaver

Professional societies have responded to concerns about real or perceived conflicts of interests pertaining to their leadership, guideline committees, and meeting costs with a series of measures. Insurmountable, seemingly, is the bare fact that members and government funds cannot cover the full costs of doing business for a major professional medical society. According to a recent editorial by ACC outgoing president **Dr Doug Weaver** (Henry Ford Health System, Detroit, MI), industry covers approximately 38% of the college's revenues [3]. "Without this support," writes Weaver, meeting registration fees "would have to be more than double their present amount, and member dues would have to increase significantly."

That said, the ACC appears to be doing what it can to distance itself from any real or perceived industry influence. At the recent ACC Scientific Sessions, the ACC passed up, for the first time, more than half a million dollars in revenues by opting to decline sponsorship for their bags and lanyards.

Those types of efforts, however, do not go far enough to satisfy an increasingly vocal group who say everything possible should be done to shield professionals and their umbrella organizations from industry influence. Again in *JAMA*, a recent editorial by a diverse group of physicians led by **Dr David J Rothman** (Columbia University, New York, NY) lays out a 10-point proposal for eliminating financial conflicts of interest related to industry funding [4]. Their proposal tackles everything from general budget support; support for publications, congresses, research and training funds, practice guideline development, and product endorsements; and potential conflicts among professional society leadership. The bottom line, say the authors, is that professional medical societies should work toward zero-dollar contributions from industry: a lofty goal.

It's very, very hard to bite the hand that feeds you, even when it needs to be bitten.

Dr Steve Nissen (Cleveland Clinic, OH), a coauthor on the *JAMA* editorial, acknowledges that zero is an ambitious target, noting that the group proposes an initial goal of <25% industry support. This gives organizations a chance to transition out of their dependence on company funds, he says.

Dr Steve Nissen

"The more entwined professional societies are with industry, the less independent they are likely to be. There was a lot of discussion [among the editorialists] around some of the controversies that have erupted in recent years, where the professional societies haven't necessarily always lined up on the public-health side of things. I agree: it's very, very hard to bite the hand that feeds you, even when it needs to be bitten."

ACC CEO **Dr Jack Lewin**, however, argues that a zero target is not only impossible; it's inappropriate. Without "cordoned-off" industry funding, the college would be forced to up its dues and meeting fees; as a result, more and more physicians and allied health professionals would simply stay home.

"There's no doubt, if COI policies were to be applied like those [proposed in Rothman et al's] article, then I think we'd have a regression of evidence at the point of care, and you'd be hurting patients," Lewin told **heart*wire***. "A partnership with industry, if well managed, is good for society and good for patients."

Dr Jack Lewin
(Source: ACC)

Lewin continued: "The most stunning thing about that editorial is that they don't seem to understand that conflicts with industry can be ethically and appropriately managed to protect patient-centered values and keep physicians free of bias."

Others, like **Dr Harlan Krumholz** (Yale University, New Haven, CT), also support a "well-managed" approach. "There are people saying there should be no relations [between physicians, societies, and industry], but a lot of us think that's too draconian. But there does need to be a preponderance, particularly in guideline-writing committees, of people who are without overt relationships."

Past president of the **American Heart Association** (AHA), **Dr Dan Jones** (University of Mississippi, Jackson), told **heart*wire*** that the AHA is also striving on multiple fronts to improve transparency and minimize conflicts, and paying special attention to guideline writing groups is one of them. Others include more use of discussants or discussion panels following presentations of trials at the meetings and asking presenters to disclose their conflicts in multiple public settings—slides, disclosure booklets, and orally on the podium.

"But even the best efforts at transparency clearly lead to some important questions," he admits. "We attempt to make the public more aware, but any attempt to further explain the process looks overly defensive, and unfortunately most of this conversation occurs around an event where there are questions being raised about appropriate management of conflicts."

"Modest" or "significant" according to the AHA and ACC

The ACCF/AHA Consensus Conference Report on Professionalism and Ethics defines a "significant" COI as $10 000 or more, while "modest" is anything less than $10 000 [5].

The view from Mars

Medicine . . . is incomparably better today than it was when I started, and it's not because doctors are smarter or more professional, it's because of the good stuff we get from companies.

Any debate over COI disclosure will splinter into discussions of what kinds of conflicts are permissible—if any—and related to this, the murky business of transparency. Some argue that the two cannot be disassociated. Nissen, for one, argues that physicians can work with industry, but if they want to maintain their independence, they can't accept the money—he himself has passed up on industry payments for the past five years. "This allows me to have the scientific interaction that's appropriate but without the financial links that at some point might compromise my independence or their view of my independence," he says. "This is an area where appearances are reality."

Others counter that physicians who give their time, intelligence, and ingenuity to a commercial enterprise deserve to be reimbursed. But when they are, the public perception is that somehow they must be tainted for having accepted any payment for their efforts.

The victim, in the end, is innovation in medicine, according to one of the most outspoken supporters of industry–physician collaboration, **Dr Thomas Stossel** (Harvard Medical School, Boston, MA). He calls himself the "lone lunatic" trying to change not how disclosures are managed, but the public's incomprehension as to why they exist.

Dr Thomas Stossel (Source: Shawn G Henry)

"What the critics are saying is that medicine and science are supposed to be done by disinterested robots, which has never been true. I've been in medicine for 40 years, and it is incomparably better today than it was

when I started, and it's not because doctors are smarter or more professional, it's because of the good stuff we get from companies."

Dr Eric Topol

Stossel continues, "I'm not against disclosure, I'm against the finger pointing that goes with it. We have regulations now that say that medical students need to be trained in conflicts of interest. I always say, How about training them in how investment works to get us new products? and people look at me like I'm on Mars. Nobody gets this."

Added to that is the problem that inventors and drug developers may know the most about the product they created.

"People will say, I invented this device, I'm the only one who knows how to work it appropriately, and if I don't stay involved the whole thing is going to fail," **Dr Eric Topol** (Scripps Clinic, La Jolla, CA) told **heart*wire***. "There may be something to that, but obviously, if the device is really as good as it ought to be, it's got to be transferable. . . . The adage is, you can be rich or you can be famous, but you shouldn't try to be both at the same time."

Unintended consequences

Ironically, all of the best intentions driving improved disclosure efforts have had the unintended effect of also heightening awareness and breeding cynicism. Anyone attending the major meetings has heard the derisive snorts when a well-known pitchman for industry declares from the podium having "no major conflicts" or shows a disclosure slide in 8-point type containing 100 company names flashed on screen for a nanosecond. Some point out that more and detailed disclosure may in fact be obscuring more than it reveals: no matter how many layers are peeled from an onion, it still stinks.

Dr Harlan Krumholz

Krumholz blames aggressive marketing by industry, where companies woo prominent cardiologists to subtly promote their products or emphasize good results over others. These strategies, he says, have "interceded on the science side to the extent that sometimes it creates behaviors and forces that are not necessarily in the public interest."

He describes two back-to-back talks at a major meeting, one by a physician given a slide set promoting messages developed by a marketing team and another by someone who has received legitimate financial support to give a talk but made his own slides based on his own ideas. "Those two talks can look exactly the same: famous person, sharp slides, clear message, and a disclosure of some support or relationship with industry. How do you really differentiate the honest forthright presentation of scientific information by someone who is independent from someone who is being handed a slide set or is part of a speaker's bureau?

It's very difficult."

Topol points out that part of the confusion and the "erosion of trust" stem from the difficulty of making disclosure statements concise but informative. Industry grant support is a fundamental driver of clinical research, but these kinds of payments are typically lumped with honoraria, speaker's bureau payments, and even stock equity, he says. Moreover, disclosure slides at meetings or statements in journals never give dollar amounts.

There's a big lack of comfort about this, but there hasn't been a good solution proposed for how to deal with this in a consistent, transparent, and effective way.

"A lot of times the [financial details] are requested by the journal and it's not put in the article, or it's widely known and put on blogs, but not where it counts," Topol says. "A lot of information is suppressed either in the way the process is set up or how it's made public. There's a big lack of comfort about this, but there hasn't been a good solution proposed for how to deal with this in a consistent, transparent, and effective way."

Califf believes he has at least a partial answer. He wants a single, publicly accessible repository where people would post and be required to regularly update all of their financial conflicts of interest. This would have the added benefit of sparing investigators from hours of duplicative paperwork required when they submit papers to journals, participate in FDA hearings, give lectures at conferences, or speak with the press. He also sees no problem in publicly disclosing financial numbers.

"We all file tax returns, so we have that information—why not disclose it in a public place?" Califf asked. Being ashamed that your advice is worth a lot of money seems kind of silly to me."

Dr Dan Jones
(Source: University of Mississippi)

Jones points out that not a month goes by without the AHA revisiting its COI-disclosure process—in part to ensure the association is doing its transparent best, but also so that it can be *seen* to be doing its best.

"Ultimately, the public will have to decide," he says. "If there is a higher comfort level in being sure there are no conflicts, it will clearly diminish the entrepreneurial efforts and likely reduce the scientific productivity. On the other hand, if we continue in an environment where there are commercial interfaces with organizations, we will continue to struggle with management of COIs. That's the reality of that tension."

Stossel, for his part, says medical societies, journals, and individual physicians worry too much about public perceptions. "Politics is about perceptions, but medicine and science are not; they're about data. If we let perception rule the world of science, the world is flat. We need education about how science and medicine really work."

Stossel believes more physicians like him should be speaking out to make the public understand why physicians work with industry. He gives the example of a researcher who invented an important product but then fumbled questions from the *New York Times* as to how much he made when a multinational company bought his invention. "What he should have said was, yeah, I got two million dollars from company X and the reason is, I'm good. I've done more for end-stage renal disease in this country than anyone else, and if I weren't any good, I'd be a *Times* reporter."

Krumholz, however, says Stossel and others are "missing the point."

"The point is, there *has* been really bad behavior, and how do you avoid that not by prohibiting relationships but ensuring that they are in line with the best interests of society? It's not that easy."

Less tangible conflicts

But for all the rumors and publicity surrounding cardiologists who seem to be handsomely paid by industry and then do or do not disclose it, there is just as much around those who, very publicly, decline their payments. A feature story last year in the *New York Times* profiled prominent physicians, **Dr Peter Libby** (Brigham and Women's Hospital, Boston, MA) among them, who decline all payments from industry [6].

"At last, they say, when they offer a heartfelt and scientifically reasoned opinion, no one will silently put an asterisk next to their name," *Times* reporter **Gina Kolata** wrote.

Such a statement, however, produces grumbled dissent in the cardiology community, where physicians are quick to point out that the whole issue of COI disclosure runs far deeper and is infinitely more complex than the *Times* article suggested. Even at the most basic level, personal reputations, "intellectual conflicts," a career dedicated to specific treatments or theories—these are the kinds of things that will never find their way into disclosure statements but inevitably exercise a profound influence on a person's advice, practice, and opinions.

If we let perception rule the world of science, the world is flat.

But even on a purely financial level, most of the world's most prominent cardiology "thought leaders" now assiduously declining industry support have only started doing so in recent years—many of them having done their moonlighting for industry and obtained their first mortgages long before disclosure was ever a buzzword. Many owe their renown and even their current academic posts in part to the fact that companies paid them to travel and speak at meetings without ever having to mention the troublesome fact of who was picking up the tab.

"It's easy for someone like me," says Califf, "or a Steve Nissen, a Peter Libby, or a Bob Harrington to say, 'I take no money from industry'—we're in the higher salary bracket, I would guess, compared with most academics. But what about our junior faculty? Our assistant professors? They're not making the kind of money where they can just pay for their own trip to Paris for an international consultants' meeting with Aventis."

Nissen doesn't deny that heightened awareness of COIs is hitting junior faculty harder than it is people like him. "The problem we have is that in some academic medical centers, the salary level, particularly for junior people, is very low, much lower than it would be in private practice, so the temptation to give lectures or programs on behalf of industry is very high. The answer to that problem is not to have every young faculty member be on the take, the answer is to find a way to pay people appropriately for the role they play in educating future physicians."

But Nissen bristled at the reminder that he accepted payments that he and others now loudly renounce: "I can't change the past," he says. "None of us can. But what I can do is set an example going forward."

A complicated thing

Most people admit there's no easy way to fully disclose COI. A growing number of physicians claim to have no "personal" conflicts of interest because they direct all funds—for consulting, for patents, for speaking engagements, for research—to their hospital or academic institution. But as Levine points out, this isn't exactly altruism pure and simple.

Dr Glenn N Levine (Source: Baylor College of Medicine)

"I think that the speakers who do not take honoraria are to be applauded and that they are truly in a good-faith effort doing what they think is best," he says. "But I think the situation is vastly more complicated, where institutes may be receiving significant funding and that funding in part may go to support either research or salaries. This is no fault of the people who are not taking honoraria—they really can't do anything about the other issues—but I think it makes the situation more complicated than can be addressed by any one speaker in a slide or disclosure table."

Most of the time, he points out, money channeled to an institution is used to supplement salaries, research support, or obtain the kind of cutting-edge equipment that leads to a self-perpetuating stream of revenue. "It's an incredible challenge, if not an impossibility, for people to try to overcome any potential, indirect sources of revenue or research support related to industry that in some ways might ultimately benefit them," Levine says. "This is how most of research works these days. Unless the [**National Institutes of Health**] were giving out absurd amounts of money and were able to fund every study that we wanted to do, this is the system, and we have to make the best out of it."

Califf agrees: "Our own conflict-of-interest committee at Duke concluded that even if you take no money you still need to report it as a conflict. So even trying to say 'I take no money' is a complicated thing."

The way forward

Almost everyone who spoke with **heart*wire*** expressed trepidation that more disclosure, while necessary, seems to be doing as much harm as good. Hardworking physicians and researchers are drowning in COI paperwork and fretting about the impact on their reputations, while the people truly trying to hide an embarrassment of industry riches still have ample means of covering their tracks. Most agree, however, ever-more disclosure is probably the only way forward.

> **No matter who the person is, when you're listening to someone's talk, you need to really be a critical thinker, and you need to be asking tough questions about everything you hear.**

Lewin gives the example of guideline statements, saying the ACC frequently has to remove renowned experts from the writing groups on the basis of financial conflicts. "If something in a guideline comes out, we want to trust that this is truly the best science and the best judgment of our peers, and not something that's biased by intellectual conflicts or conflicts related to industry. Otherwise people aren't going to use these things. You've got to go to whatever costs and lengths are necessary to manage relationships with industry and to manage conflicts transparently."

Krumholz and Nissen call for stricter regulation of industry-sponsored CME and particularly third-party CME-companies—some of them sponsored by a single drug or device company—so that the role of specific companies in promoting specific strategies is clearer.

"We've gotten into this fix in part because the [**Accreditation Council for Continuing Medical Education**] is an

inept organization that's been very ineffective at policing CME, and as a consequence they've left this largely as a wide-open area for what I think is a lot of inappropriate CME that's highly promotional. It's all done with a wink and a nod. There are not just professional medical societies but also medical communication companies who specialize in providing CME that are single-vendor sponsored," Nissen said.

That doesn't necessarily mean no money changing hands, Krumholz suggests. "The answer, I believe, shouldn't be in separating industry, academics, and practitioners but in finding ways for us to come together where we can both disclose our personal interests but also make sure we're putting the interests of patients first. To me, that's about tamping down some of the marketing efforts that are going on by companies and augmenting the scientific discussions that need to take place about the proper placement and use of drugs."

And ultimately, he says, physicians need to take it upon themselves to filter information.

"No matter who the person is, when you're listening to someone's talk, you need to really be a critical thinker and you need to be asking tough questions about everything you hear," Krumholz advises. "Whether a person is sponsored by industry or not, everyone has different opinions, and you have to listen carefully and see whether you're really persuaded by the information you've heard."

For several years, **heart*wire*** *has had the policy of asking anyone we interview whether they have any relevant COIs and disclosing them in a box like this. We also include any disclosure information provided in published papers, meeting presentations, and/or disclosure booklets—an imperfect process that relies on physicians/researchers to be upfront. We make every effort to interview people with a diverse range of opinions, seek "outside" comment as much as possible, and have* never *knowingly allowed our stories to be influenced by an advertiser or other industry supporter's wishes. All editorial content on* **theheart.org** *is kept strictly separate from advertising and sponsored programming —distinguished on* **theheart.org** *by blue-gray shading and prominent mention of the sponsor.*

Sources

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