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It Is Time to Move Beyond a Culture of Unexamined Assumptions, Recrimination, and Blame to One of Systematic Analysis and Ethical Dialogue

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Conflicts of interest are a big topic in medicine today. There is a proliferation of articles, guidelines, and rules providing advice about how to address what is widely regarded as a rampant problem (Zinner et al. 2010; Rockey et al. 2010; Licurse et al. 2010). Despite the large quantity of materials, however, the quality of thinking and analysis is generally very poor. In part, this is because the whole field is dominated by a few basic assumptions that are simply incorrect. The article by Brody (2011) exemplifies this literature and these errors. In this commentary we draw attention to these mistaken assumptions and present a more rigorous and, we believe, more effective approach to the identification and management of conflicts of interests.

What are the mistaken assumptions? Starting from the rather perplexing assertion that "medicine is a social role," Brody asserts that a conflict of interest entails a physician "unnecessarily" entering into "a set of social arrangements" that are "morally blameworthy," in that they carry the risk of "tempting" him or her away from "patient-centred duties," or "patient advocacy," in favour of a personal (or third party's) interest, and thereby threatening public trust (Brody 2011). Each of these assumptions is wrong: The circumstances under which conflicts of interests occur may or may not be avoidable; they need not be blameworthy; they may have nothing to do with "patient-centeredness," advocacy, or any other specific value; they need not assume any particular moral hierarchy; and they may have nothing to do with public trust.

Why is the thinking about conflicts of interests so confused? The most obvious answer is that little effort has been made to clarify the underlying concepts, notably the meaning of the term "interests" itself. In addition, while the literature—including Brody's article—is full of normative proclamations about the proper values and conduct of practitioners—often defined differently by different authors—it ignores the cultural pluralism and moral diversity of modern society and the

communities doctors seek to serve. This diversity and pluralism are critically important, as they are the key both to understanding the deficiencies of the extant literature and to establishing a secure, well-founded framework for identifying and resolving conflicts independent of arbitrary prejudices and assumptions.

The Royal Australasian College of Physicians has, over a decade, developed an approach that we believe satisfies these needs. It is summarized in a set of "guidelines" that were developed after extensive consultation involving both the medical profession and the broader community (Komesaroff et al. 2006). These guidelines are not promoted as a formal policy to be implemented and enforced but as a guide to a pedagogical process, an opportunity to stimulate and foment reflection and debate, and a means by which to engage the relevant communities in a manner that enables them to develop their own structures for responding to the issues that confront them.

The concept of interest, although crucial, is not complicated. The definition we use is adapted from the broad formulation of Immanuel Kant two hundred years ago: An interest is a "commitment, goal or value, arising out of a social role or practice" (Kant 1964). It should be noted that this analytical statement does not entail a judgment, although it does recognize that practices may be linked inherently to values and value commitments.

It is a fact of modern life that we are all embedded in a multiplicity of social roles. In traditional societies only a limited number of roles was accessible to an individual. Today, one can be—simultaneously—a physician, a researcher, a teacher, a university administrator, a member of a government committee or a drug company advisory board, an active member of an ethnic community or religious group, a parent, a partner, a political activist, a citizen, and many other things. Each of these roles has—or may have—associated with it a set of ethical duties or moral injunctions, none of which is self-evidently more worthy or honorable than any other. For the most part, it is possible for an individual to occupy the overlapping roles harmoniously. However, from time to time, within this plurality of interests a conflict can erupt. For example, if I am researching my own patients, my obligation as a researcher may conflict with my obligation as a physician. If we are discussing overlapping commitments, my duties as a member of the government committee may conflict with my religious beliefs, and so on. Note that these "conflicts" need not extend globally to the whole social role; there may be plenty of things I can do as a member of the committee and as a devout follower of my religion, or as a doctor and as a parent, and usually there are only a few that represent conflicts involving two or more roles. Conflicts of interest are, therefore, specific and local, and are not related inherently to the roles themselves.

Who is affected by a conflict if it occurs, and what should be done about it? Clearly, the conflict is of importance for the specific communities involved in or represented by the conflicting social roles. They are, after all, the sources of the values and those whose "interests" stand to be compromised. Accordingly, they are also the appropriate focus of any remedial actions that might be required.

From these simple and largely uncontroversial observations it is possible to elaborate a detailed, logical process for identifying and responding to conflicts of interests. (Komesaroff et al. 2004; 2006) Here are some simple steps in this process:

1. There is a need to identify interests. This means that it is a responsibility of each individual to reflect on the nature of the moral imperatives attached to any particular social roles he or she is occupying at a given time.
2. These interests are inherently not personal but social, and should therefore be declared, according to an agreed process, to the members of the community.
3. Whether, in a particular case, the plurality of declared interests includes a potential, or actual, conflict of interest is not for the individual but for the community, through its agreed process, to decide. This is a reminder that a conflict is not a psychological condition but a sociological one: It exists not in the mind of the individual concerned but in the facts. The

question the community needs to answer is whether the plurality of interests is likely to lead to compromise of any key duties incurred by its own members.

4. If there is a conflict—that is, if it turns out that the interests associated with the overlapping social roles tend pull the individual concerned in two, or more, different directions simultaneously—the community has to decide whether anything needs to be done about it. Not all conflicts of interests are of profound significance and in many cases communities abide occasional transgressions and incongruent actions.
5. If a conflict of interest is judged to be sufficiently important that it may lead to significant adverse consequences, then something does need to be done. This is usually not complicated because the structure of the conflict generally defines its own resolution. What is needed is to tease the two social roles apart at the exact point where they overlap and contradict each other. If, for example, the problem is with recruiting one's own patients to a clinical trial, then someone else should be delegated to take on this role. Or if the problem is that one's membership in a drug company's scientific advisory board conflicts with one's membership in a committee charged with developing a clinical practice guideline for treatment of a condition in which that company has a commercial interest, then one should decline membership of that committee.
6. Although usually the solution to a conflict is straightforward, sometimes it necessitates complex organizational arrangements. Whatever the strategy, however, the outcome has to be communicated to the community group for ratification, as ethical discourse within communities is both the starting point and the endpoint for the process of identifying and responding to conflicts of interests, and communities have to have confidence that they are being protected. This is not to suggest that every detail regarding interests, pluralities, and conflicts need be communicated, for what may often be sufficient is a reassurance that there is in place an open, uncoerced process by which interests can be identified and tested systematically within the communal culture.

Several key points in the process just given may be noted: It involves objective, factual analysis; it is democratic and public; there is no suggestion of blame or ignominy; there is no assumption about who is right or wrong or whether some particular practice—such as medicine—is ethically worthier than any other; there is no reliance on gratuitous assertions about particular values that should predominate; and it emerges organically out of the practices of the communities, which it thereby enriches and strengthens.

While this approach requires that the institutions and communities involved establish the framework and related policies to support the dialogues at the various stages, this need entail no more than the formal approbation of open and unforced dialogue within the structures of the community. In saying so, however, it is important to recognize that the fostering of capacity to undertake such dialogues is not necessarily straightforward and cannot merely be imposed by the promulgation of guidelines; rather, it needs to be supported by constant debate and argumentation. The approach that we outline requires valorization of, and support for, ethical discourse, and for this there is no shortcut.

It is time we moved from cultures of recrimination and blame, from arbitrary assumptions and lack of analysis, to a process built on rational analysis and free ethical discourse.

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