

Voice of Experience

Bias, Power, Influence, and Competence: The Implications of Human Nature on the New NIH Conflicts of Interest Regulations

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Voice of Experience advances the tradition of service of the Journal of Research Administration by fostering consideration of and reflection upon contemporary issues and concerns in research administration. VOE is a celebrated feature column in each edition of the Journal. In this issue, J. Michael Slocum, Journal of Research Administration Intellectual Property Counsel, presents a review of recent literature concerning conflict of interest as one of the key standards in research ethics. This is discussed in light of the relationship between physician and patient and what that means for informed consent.

Introduction: Rules and Policies, or Ethical Culture

"The forbearing use of power does not only form a touchstone; but the manner in which an individual enjoys certain advantages over others is a test of a true gentleman. The power which the strong have over the weak, the magistrate over the employed, the educated over the unlettered, the experienced over the confiding, even the clever over the silly; the forbearing and inoffensive use of all this power and authority, or the total abstinence from it, when the case admits it, will show the gentleman in a plain light."

— General Robert E. Lee (As in Bradford, p.233)

The looming advent of the deadline for revised conflicts of interest regulations imposed by the National Institutes of Health (42 CFR Part 50 & 45 CFR Part 94) has made me muse on the continued emphasis on new policies, procedures and rules to be developed by research institutions. It seems to me (and many other commentators) that policies and rules concentrating on disclosure are too often seen as the panacea for the ethical and legal problems that arise from such conflicts. As Regan has said, there is not an "appreciation that even if an organization has adopted elaborate rules and policies designed to ensure legal

compliance and ethical behavior; those pronouncements will be ineffective if other norms and incentives promote contrary conduct" (Regan, p. 942). Regan further states:

Responding to the call for creating and sustaining an ethical culture in organizations requires appreciating the subtle ways in which various characteristics of an organization may work in tandem or at cross-purposes in shaping behavior. The idea is to identify the influences likely to be most important, analyze how people are apt to respond to them, and revise them if necessary so that they create the right kinds of incentives when individuals are deciding how to act. (Page, p. 942)

We See What We Want to See

This daunting task is complicated by basic facts of the human psyche and the nature of organizational behavior. Many others have recently made the point that we are often good at seeing the mote that is in another's eye, but not the beam that is in our own (Regan, Young, Page, Gospel of Matthew 7:3). These make the point (with citation to overwhelming scientific proof in the case of the more recent writers, if the simple observation in the Bible was not enough) that it is often easy to see how others may be biased. They also document, again with many citations, that it is much harder to recognize one's own biases.

As Page says, "The simple fact is most of us believe that we are capable and impartial decision-makers ... Not only are we capable and impartial, we are more capable and impartial than others. ... Ethical decisions are biased by a stubborn view of oneself as moral, competent, and deserving, and thus, not susceptible to conflicts of interest. To the self, a view of morality ensures that the decision maker resists temptations for unfair gain [and] a view of competence ensures that the decision maker qualifies for the role at hand ..." (Page, pp. 278-279)

This inability to see one's own biases extends to organizations and not just individuals. The cognitive processes and behavioral economics that underscore many of our individual tendencies are intensified in the organizational setting. Therefore, on an organizational level, as with each of us as individuals, efforts to promote ethical behavior are most likely to be successful if they build on durable human tendencies, instead of fighting natural human instincts.

As so succinctly stated by Young, "The idea that scientists are objective seekers of truth is a pleasing fiction, but counterproductive insofar as it can lessen vigilance against bias" (Young p. 412). Similarly, the idea that universities and other research institutions are pillars of impartiality and purity is, at best – naïve.

Concern that the business community wields undue influence over American universities is at least 100 years old. AAUP's founding 1915 "Declaration of Principles on Academic Freedom and Academic Tenure" observed that the "governing body of a university is naturally made up

of men who through their standing and ability are personally interested in great private enterprises.” At [universities], businessmen (they are overwhelmingly men) do dominate the board, and most are leaders of [the] FIRE (Finance, Insurance, and Real Estate)-based economy. ... “[C]orporate universities,” ... are distinguished ... not merely by the extent of corporate domination of their boards but also by their extensive adoption of corporate structures and policies.

Corporatization develops as universities become diversified enterprises with revenues derived not only from on-campus tuition but also from extension, on-line and overseas programs, campus services, investments, real estate holdings, research, patents, industrial parks and partnerships, sports and entertainment, and medical and other professional services. University presidents and senior administrators thus become managers, fund-raisers, and competitive entrepreneurs. (Benjamin, p. 255)

This unrecognized bias experienced by the individual and by organizations of individuals is iterative – a constant feedback loop of good feeling and self-justification that can assure that unethical behavior is neither seen by the actors, nor policed by those charged with compliance in an organization. In fact, the simple fact that an individual is a part of a group is a major source of bias – called “in-group” bias.

In-group bias is the general “tendency to evaluate one’s own groups more positively in relation to other groups” (Page, p. 249). Page’s summary of this concept is highly instructive in the realm of academia.

In general, the stronger the group ties or similarities, the stronger the bias, but groups based on as little as pleasant social or professional contacts can also lead to biased decision-making based on unconscious cognitive, affective, and motivational processes. Repeated exposure to people “tends to enhance their subjective value,” and therefore also increases the bias. This can occur even when people have no conscious awareness of exposure. **Members of high status or high power groups generally have higher levels of automatic in-group bias than members of groups with lower status or power, as do more loyal members** (Emphasis added and internal references removed.) (Page, p. 251)

Page’s review of bias and conflict in the corporate boardroom is equally appropriate for the research organization. As he says,

It is uncontroversial that people are self-interested. People will generally seek financial and social benefits for both themselves and close family members. [People] are likely to prefer outcomes that serve their pecuniary and social needs. (Page p. 253)

Page's review of the underlying reasons for bias is even more relevant to academics and their research institutions when he turns to the non-monetary realm. Social rewards may be even more important than pecuniary. Doing something for which one is recognized by others contributes to one's sense of self-worth. For both the individual and the organization, that sense of worth may be more valuable than any "filthy lucre." "... [T]he way in which the outside world expects a company to behave and perform can be its most important asset." (Engardio & Arndt)

Page and many other commentators have noted that persons (particularly high-status persons) are not solely motivated by a desire to enrich themselves or their families or enhance a group to which they belong. They are motivated to maintain a desirable self-image and to be competent. There are many reasons to "do a good job," such as a sense of honor; feelings of responsibility; a sense of obligation to the organization; and a simple desire to do the right thing. As social and socialized beings, we want to be seen (and to see ourselves) as fair and even handed.

This leads to what is called "motivated reasoning," where motivation refers to any wish, desire or preference that concerns the outcome of a given reasoning task.

...man always believes more readily that which he prefers. He, therefore, rejects difficulties for want of patience in investigation; sobriety, because it limits his hope; the depths of nature, from superstition; the light of experiment, from arrogance and pride, lest his mind should appear to be occupied with common and varying objects; paradoxes, from a fear of the opinion of the vulgar; in short, his feelings imbue and corrupt his understanding in innumerable and sometimes imperceptible ways.

(Bacon, p. 1620)

These normal human thoughts and emotions indicate that most, if not all, of us are frequently unable to put aside our biases, regardless of our good intentions. Our "hard-wired" cognitive processes, conscious and unconscious, inexorably affect our decision making. This unrecognized bias and motivated reasoning make "regulatory" governance of ethical issues ineffective and even counterproductive (Page, p. 286). This is made even more apparent when particular relationships and common responses to bias and conflict are discussed.

The Doctor Knows Best

Recently, there has been a seeming explosion of interest in the nature of the relationship between the physician and patient. In the most recent editions of the *New England Journal of Medicine*, there are two articles related to this relationship – (Truog) *Patients and Doctors – The Evolution of a Relationship* and (Barry & Edgman-Levitin) *Shared Decision Making – The Pinnacle of Patient-Centered Care*. Truog makes the crucial statement, that "The relationship between patients and doctors is at the core of medical ethics, serving as an anchor for many of the most important debates in the field." He goes on to note that,

“The relationship between patients and doctors in the clinical realm has historically been framed in terms of **benevolent paternalism**” (Emphasis added) (Truog, p. 581). This is apparently still the case. In a recent commentary, another doctor questioned whether it is “...a patient’s role to know what he or she wants? Is the patient even capable of accurately evaluating the options? And having been diagnosed with an illness, is a patient’s emotional state conducive to clear decision making?” (Corn, p. 123)

There has been a push for increased disclosure by doctors of potential conflicts of interest and “informed consent” to overcome the “doctor knows best” attitude. The NIH regulations, as well as in the equivalent regulatory issuances of the Food and Drug Administration (FDA), the Securities and Exchange Commission, the courts, and various bodies charged with assuring “ethical” behavior by professionals and business persons and the organizations in which they work, all use disclosure of actual and potential conflicts as a prime tool.

A recent publication of the National Academies of Medicine stated, “As Supreme Court Justice Louis Brandeis (1914) famously expressed it, ‘sunshine is said to be the best of disinfectants.’ In a similar vein, the code of ethics of the American College of Physicians suggests that physicians considering the acceptance of gifts or other relationships with companies should ask themselves what their patients, the public, or their colleagues would think about the arrangement” (citations omitted.) (Lo & Field, p.67)

However, Emanuel, Wendler & Grady have stated, “Many believe that [disclosure and] informed consent makes clinical research ethical. However, informed consent is neither necessary nor sufficient for ethical clinical research” (Emanuel, Wendler & Grady, p. 2701). Their research and that of many others indicates that the emphasis on disclosure as the “best of disinfectants” may be misplaced. Another recent article does an admirable job of surveying the actual science on the role of disclosure of conflicts and comes to some very disturbing conclusions. Citing at least six studies, the authors conclude that, “Empirical evidence of research participants’ desire for information about financial relationships demonstrates that financial incentives matter to **some** potential research subjects” (Emphasis added) (Boozang, Coleman & Greenwood, p. 252). Several of the studies cited indicated that only a minority (although usually a large minority) wanted disclosure of financial interests of the researchers. The authors also surveyed the research and found that most studies supported the finding that, “Although a subset of research participants is interested in receiving information about financial incentives, it does not appear that the information is likely to affect many individuals’ ultimate decision to participate.” (Boozang, Coleman & Greenwood, p. 253)

Interestingly, this same problem exists for **other scientists** reviewing scientific studies conducted by their colleagues. Because of in-group bias, motivated reasoning, and a lack of any basis for rational skepticism, reviewing scientists (i.e., “peers”) simply do not question other scientists’ research findings, even when otherwise damaging disclosures of conflict of interest are disclosed.

Robertson found that for physicians trying to evaluate the quality of scientific reporting, “In practice, the value of disclosures is quite limited” (Robertson p.366). In fact, Robertson’s survey of the empirical research finds support for the proposition that, “... mandatory disclosure of conflicting interests does not even purport to prevent science from being biased. It is a downstream remedy, one that attempts to break the chain between biased science and biased medicine” (Robertson p. 369). Robertson cites other experimental research suggesting that disclosure mandates may actually exacerbate the biases in science. (See Cain, Lowenstein & Moore; Li & Madarasz)

Does Disclosure Really Help Avoid Undue Influence?

In the spirit of *Freakonomics*, when attempting to objectively analyze (and change) behavior (whether economic or otherwise) one should usually begin with a mountain of data and a few simple questions (Levitt and Dubner). Quite a few authors are taking this approach to analyzing the role of disclosure in preventing or controlling bias. Many of these analyses are concerned with the relationship between doctor and patient. Somewhat surprisingly, several of the authors who have analyzed the “data” have done so in law review and other articles not normally seen by the research administration and management community. The articles have also focused on what might be done to deal with the inherent difficulties of using the informed consent process (in research and in other areas of compliance and ethics) as a tool to combat bias.

In each of the various analyses there is an understanding that the nature of the particular relationship involved affects the efficacy of disclosure as a guard against “undue influence” on the research subjects, and against biased science. Cain and his colleagues provide experimental evidence that disclosure can fail because it (1) gives advisors strategic reason and moral license to further exaggerate their advice and (2) it may not lead to sufficient discounting to counteract this effect. Robertson delineates the various decisions made by researchers that in some cases transform, distort, or even disguise the actual empirical underpinnings that scientists, regulators, juries, physicians, and especially patients rely upon to assess the safety and adequacy of industry products.

Boozang, et al note that disclosure could very well help “most those who need help least and help least those who need help most,” thereby increasing the disparity between educated and uneducated, or rich and poor (Boozang, Coleman & Greenwood, p.263). They cite Ben-Shahar, et al, whose excellent article discusses the role of disclosure in policing many different kinds of conflicts. Ben-Shahar et al argue that disclosure not only fails to achieve its stated goal but also leads to unintended consequences that often harm the very people it intends to serve.

All of these analytical insights point to the potential for science biased as a result of the researcher’s (or institution’s) conflict. However, they also repeatedly identify problems that arise when the basic legal concepts of “undue influence” comes in contact with the

equally basic tendencies of those less powerful to be dependent, for better or worse, on the more powerful.

Undue influence is a core concept in the law, commonly learned in the first year of legal studies. The principle arises when a person, without independent advice, enters into an “unfair” transaction, with bargaining power impaired by his or her needs or desires, or by his or her ignorance or infirmity. If that transaction is even partly the result of “improper” influence or pressures applied for the benefit of another, then the law will consider stepping in. This is not a matter of purposeful coercion apparent to all parties in cases of duress (as was experienced by the prisoners in Guatemala or the children in Nigeria) (Postal and Whipple Diaz). The concept of undue influence looks to more subtle indications of impropriety and overbearing behavior that may indicate some abuse of power made possible by the trust and confidence in the parties’ relationship. (Barnhizer)

Many legal systems impose duties on strong parties and grant rights to weak parties. Examples include protection of rights related to access to information, notification of risks or potential rewards, and supervision of persons in positions of trust (i.e., fiduciaries). One commentator (Koops) sees the legal system as viewing consumers (i.e., research subjects, students, patients, and actual consumers of products arising from the research) as intrinsically disadvantaged requiring “structural inequality compensation,” triggered by the mere fact of belonging to the class of the weak party in the power relation. This concept of protecting the weak has been incorporated in many ethics “codes” covering even disfavored populations. For instance, Postal and Whipple-Diaz note that prisoners were originally given “**vulnerable population**” status in 1978, and are now protected under 45 C.F.R. § 46.301 et seq. (Emphasis added.) (Postal and Whipple-Diaz, p.4)

Are Doctor and Medical Institutions Capable of Being “Trusted Servants?”

The doctor-patient relationship has long been seen as fiduciary in nature (Matthew). The fiduciary relationship is one requiring the stronger party to protect the weak dependent. This means that the doctor has a relation with the patient similar to a parent-child situation (back to that benevolent paternalism). However, legal scholars have collectively identified significant defects in the actual application of fiduciary concept in the law (Matthew). Among the earliest defects identified was that the fiduciary duty by itself is unable to constrain financial conflicts of interest in medicine as well as it works to police other persons in “trusted servant” positions (Rodwin). This is in large part because the bias in research (including but not limited to medical research) is not often blatantly pecuniary or even clearly apparent, but is based upon psychological processes and innate human characteristics that are not overcome by “elaborate rules and policies designed to ensure legal compliance and ethical behavior.”

Institutions, too, can be subject to conflicts which go unrecognized. Just over 60 years ago, in 1951, Johns Hopkins Hospital removed tissue of Ms. Henrietta Lacks, a

31-year-old African American woman diagnosed with cervical cancer. That tissue was used to mass produce “HeLa” cells. That cell line produced and continues to produce improvements in technology, biology and medicine as the reference cell in many research laboratories (Deleso). Deleso finds that Johns Hopkins is subject to the same kind of charge of unethical behavior as might be pressed against a doctor who takes advantage of a patient.

Deleso argues that Ms. Lacks’ descendants have a **present day, *prima facie*** case for unjust enrichment against Johns Hopkins University, notwithstanding that what the University did was apparently completely legal at the time. She argues that: 1) a benefit was conferred upon the University by the Ms. Lacks; 2) the University was aware, had an appreciation or knowledge of the benefit; and 3) the University accepted the benefit under such circumstances as to make it inequitable for it to retain the benefit. She argues that the University has been unjustly enriched at the expense of another and is subject to liability in restitution. Again, her analysis is based upon a stronger party taking advantage of a weaker, more vulnerable party. Her discussion makes it plain that disclosure would not have changed the resulting inequity she finds compensable.

Professionals (and organizations run by professionals) rarely set out to become corrupt. However, many of them face powerful conflicting motives that make it difficult to maintain perfect professional integrity. They are granted positions of trust, given a license to affect the life and health and welfare of other humans, and rewarded greatly if they succeed, even if the client/subject/patient dies, is bankrupted, or otherwise receives no benefit. When seen in this light, the research suggests that it may be impossible for professionals to fulfill roles that demand objectivity while simultaneously fulfilling roles that demand empathy or partisanship in support of a person seen through the film of “benevolent paternalism.”

Professional codes of conduct and other “elaborate rules and policies designed to ensure legal compliance and ethical behavior” rarely provide sufficient solutions; their most frequent response to conflict of interest is to direct professionals to not be influenced by them. For example, the 2002 Code of Ethics of the American Medical Association demands that “Under no circumstances may physicians place their own financial interests above the welfare of their patients.” If physicians were to take this mandate seriously, they would provide their services free of charge. Simply denying that a conflict of interest exists does not represent a useful solution. Most often, the conflict is not even recognized and both the professional and the other party are unconscious of the problem.

If a problem is an unconscious bias, on the part of both the individual and organization, then the solution cannot be based upon conscious, seemingly rationale analysis of the costs and benefits or on “elaborate rules and policies designed to ensure legal compliance and ethical behavior.” The problem cannot be solved by threats to reputation, the risk of legal action, or any other measure intended to alter the decision maker’s **perceived best interest**. Quite simply, penalties for unethical behavior are not enough if people do not know they are acting unethically. Rather, if bias affects a decision, even when it is not desired by the decision maker, solutions must address the psychological aspects of the conflict (Tenbrunsel & Messick).

The “Lake Wobegon Effect” Applies to Identifying Bias and Conflict

This failure to recognize the effect of bias on one's decisions is particularly acute in research. One of the prime obstacles to addressing bias and improper use of the professional's power is the competence **of both the subject and the researcher** in evaluation of information provided to help us make important decisions. Ehrlinger, Johnson, Banner, Dunning, & Kruger demonstrate that "... those most confident in their level of expertise and skill are not necessarily those who should be" (Ehrlinger, Johnson, Banner, Dunning, & Kruger 2008). They note that substantial psychological literature exists suggesting that perception of skill is often only moderately or modestly correlated with actual level of performance.

This research clearly indicates that those who do not do well with intellectual tasks do not give accurate self-evaluations of their inability. This research supports Boozang et al in the assertion that disclosure is least helpful to those needing it most (i.e., the most vulnerable because of lack of education, scientific knowledge, or general intelligence). Those who most need to understand the corrosive effect of conflict are least likely to be able to do so, and those persons are also least likely to even understand that their trusted doctors may not be acting in a selfless and purely altruistic manner.

As Boozang et al continue:

Given the level of trust that pervades relationships between participants and investigators, one would imagine that only highly sophisticated or skeptical individuals would intuit that disclosures of conflicts of interest are designed to alert participants that the researcher may be acting in a self-interested manner. Further, even if prospective participants understand why the information is being provided, they would have no context within which to evaluate the information. For example, most people would have no way of knowing whether a particular conflict is significant, or whether it has influenced the study design. (Boozang, Coleman & Greenwood, p. 13)

More troubling, the same research would indicate that the least competent researchers are likely to believe that they are very competent, and the least educated in the nuances of ethical behavior are most likely to be assured in their assertion that they are completely ethical in all their affairs.

Boozang, et al; Cain, et al; Robertson; and Avraham all find that financial relationships between sponsors and investigators (and between others such as those who develop clinical guidelines and the pharmaceutical industry) should be "directly regulated." As stated by Boozang, et al, "Research participants cannot be expected to protect themselves against the risks that financial relationships pose to researchers' judgment" (Boozang, Coleman & Greenwood, p. 267). Consciously counteracting potentially biasing influences on judgment is not enough; in many cases it is impossible to adequately correct for biasing "undue influence." Where the researcher or the institution is in a position of trust, and where the subject of the research (or the consumer of the research) is impaired, ignorant or in great

need or infirmity, eliminating the temptation may be the only way to eliminate conflict of interest. (Moore, Tanlu, & Bazerman, 2010)

It should be recognized that these commentators all agree that disclosure serves important ethical values. They do not argue that financial relationships between sponsors of clinical research and investigators or research institutions should not be broadcast far and wide. However, they present strong arguments that the existing system often does not help “subjects” make good decisions about participating in clinical trials or help researchers make ethical decisions about the research they conduct. They also present good support for the proposition that such disclosures may actually harm the most vulnerable in the patient population. This should be of immense concern to those serving on Institutional Review Boards (Research Ethics Committees) and ethicists working within both research organizations and with patient populations.

If Conflicts Are Not Dealt With, The Courts Will Get Involved

If such bodies and professionals do not recognize the problems of using consent to soothe the tensions between scientific endeavor and personal gain, then the courts may be expected to become involved sooner or later. The law will intercede to protect those deemed “vulnerable,” and consent will not be a shield sufficient to protect even the most sophisticated and respected research institution. As the court in **Grimes v. Kennedy Krieger Institute, Inc.** stated:

We have three ways out ... In the first, consent is king, while the third option assumes a moral universe shaped and governed by extra-consensual considerations. The second option, however, reflects the tension between the other two. We might block the consented-to action, but we pay lip service to consent's justifying role by assuring ourselves that had the consent been untainted, had it been ‘informed,’ it would have had moral force. In fact, we pay lip service precisely because we often silently suspect that consent cannot and does not always justify. Rather than admit that the consent does not and could not justify the act, we denigrate the consent and, necessarily, the consenter as well. (Grimes v. Kennedy Krieger Institute, Inc. 2001 p. 127-8)

(Are we back to the paternalism? Benevolent or not, so it would seem.)

For the Court in **Grimes v. Kennedy-Krieger** and for the IRB, the researcher, and for the research manager, “This is cheating; it is a subterfuge designed to hide our unease and to allow us to profess simultaneous commitment to values that often conflict.”

One of the most revered principles in medical ethics has been that physicians should be devoted to the best interests of their patients. In reality, this has never been more than an ideal, since physicians have always had competing pressures (Truog 2012). Doctors in recent years are more often being portrayed as greedy and motivated by a desire to

maintain their incomes. Many doctors are concerned about what they see as dishonest and unethical conduct in the medical profession. Public confidence in “leaders of medicine” has declined substantially in recent decades. (McClurg)

Whether it is the many convictions that have been obtained against doctors who have in fact been greedy and motivated by a desire to maintain their incomes (see, e.g., Department of Justice 2012), or the sorry histories of Guatemala, Tuskegee, etc., it is clear that medical and other researchers, like all other humans, may not always act in the best interests of others. And it is similarly clear that those most confident in their level of expertise and skill are not necessarily those who should be. (Ehrlinger, et al)

As Professor Regan concludes, reasoned analysis produces only a small part of what we think of as thoughtful judgments about situations with moral implications. Most are post hoc justifications based upon what are regarded as socially acceptable reasons. For many of us, much of the time, moral reasoning is not based upon a careful analysis of what to do and why, but of rationalizations of what we have already done or committed ourselves to do. This should give us pause. Most ethics policies and rules are based upon the thought that the researchers, subjects, reviewers and regulators will use conscious deliberation to evaluate the scientific endeavor and results. Most ethics-related rules and processes contemplate reviewing various situations, providing systematic ways of reasoning about those features, and justifying conclusions about how they should be reconciled. The research shows that such organized ethical case study exercises may not affect behavior. Rather, they may serve to justify what people want to believe.

Conclusion

This has vast implications for those of us involved in setting and enforcing “compliance.” Compliance is essentially “deterrence-oriented” or “values-oriented.” There is substantial research showing that deterrence-oriented features have a positive relationship to: (1) lower observed unethical conduct by others, (2) enhance willingness to seek ethical advice, (3) increase awareness of ethical issues, and (4) improve perception of better decision-making. Values-oriented features have an even greater positive relationship to these outcomes. They also have a positive relationship with additional outcomes that deterrence features do not: (1) commitment to the organization, (2) feeling of integrity in that values and behavior at work consistent with those outside of work, and (3) willingness to deliver bad news. Finally, neither kind of orientation alone has a positive effect on the willingness to report unethical behavior, but employees are more likely to report such behavior if they perceive a combined values- and deterrence-based orientation. (Regan, p. 971-972)

As we approach the task of re-writing conflict of interest policies and procedures to meet the demands of the NIH, we should take the opportunity to evaluate just what our efforts will accomplish. Will we simply trot out the same old methodologies and wait for the inevitable failure of those methods to deter bad acts, or will we at least begin to design a system that creates and sustains an ethical culture that appreciates and utilizes more subtle

ways of shaping behavior. Will we simply say, “Don’t place your own financial interests above the welfare of research subject and others (or if you do, be sure to tell them you are doing so).” Or will we, as suggested by Regan, “... identify the influences likely to be most important, analyze how people are apt to respond to them, and revise them if necessary so that they create the right kinds of incentives when individuals are deciding how to act.” (Regan, p. 943)

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