American Journal of Law & Medicine, 46 (2020): 275-296
© 2020 American Society of Law, Medicine & Ethics
Boston University School of Law
DOI: 10.1177/0098858820933499

Beyond Disclosure: Developing Law and Policy to Tackle Corporate Influence

Jonathan H. Marks[†]

Corporate influence is one of the most pressing issues in public health. It cuts across many of our most intractable problems—from obesity to the opioid epidemic. Companies develop close relationships with public health agencies, research universities, academic medical centers, professional societies, and patient advocacy organizations—often funding medical research and public health interventions intended to address the very challenges these corporations are creating or exacerbating. How we view relationships with industry, including how these relationships are framed in ethical discourse, shapes our legal and policy responses to them. In recent years, fueled in part by the opioid epidemic, the ethical framing of industry relationships has begun to evolve in significant ways. But legal and policy responses have not yet caught up. In this article, I develop a temporal account of corporate influence, and legal and policy responses to corporate influence. This account clarifies the limitations and adverse effects of conflicts of interest disclosure, especially when implemented as the sole legal or policy response. Disclosure can illuminate corporate influence—but policymakers cannot and should not rely on disclosure to eliminate corporate influence or its effects. Nor should we allow disclosure to crowd out structural and systemic responses to corporate influence—including sequestration of and separation from private-sector entities.

INTRODUCTION

Corporate influence is the most pressing issue in public health. It cuts across many of our most intractable public health problems—from obesity to the opioid epidemic. Countless companies are making financial contributions to—and developing close relationships with—a variety of public health actors, including government agencies, research universities, academic medical centers, professional societies, and patient advocacy organizations.[1] Corporations often fund medical research and participate in public health interventions intended to address the very public health challenges they are creating or exacerbating. This has been well-documented in a variety of sectors: pharmaceuticals (including opioids), food and soda, alcohol,

[†]Director of the Bioethics Program at the Pennsylvania State University, and Affiliate Faculty in Law, Philosophy, Public Policy, and International Affairs. The author is also a barrister and academic member of Matrix Chambers, London and Geneva. He is extremely grateful to Michele Mekel, Marc Rodwin, and Sunita Sah for comments on an earlier draft. Please excuse any errors or omissions—final revisions to this piece were made during the COVID-19 pandemic.

[1]*See generally* JONATHAN H. MARKS, THE PERILS OF PARTNERSHIP: INDUSTRY INFLUENCE, INSTITUTIONAL INTEGRITY, AND PUBLIC HEALTH (2019).

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

tobacco, and vaping products.[2] How we view relationships with industry, including how these relationships are framed in ethical discourse, shapes our legal and policy responses to them. In recent years, fueled in part by the opioid epidemic, the ethical framing of industry relationships has begun to evolve in significant ways. But legal and policy responses have not yet caught up.

Systemic analyses of corporate influence reveal the ways in which corporate strategies have evolved during the last half-century. Several scholars have drawn "webs" of corporate influence in public health,[3] described the "commercial determinants of health,"[4] and characterized industry-related conflicts of interest as "public health hazards."[5] Some scholars have focused on the pharmaceutical sector. For example, Sergio Sismondo has characterized drug company strategies as "assemblage marketing"—in which doctors, researchers, and patient advocacy groups (among others) are recruited as "channel marketing partners."[6] Others have identified strategies of influence that cut across a variety of sectors (from oil and gas to opioids)—which one might expect, given that companies in different sectors have been employing the services of the same public relations, management consultant, and crisis management firms.[7] These systemic analyses make clear that the paradigm response to corporate influence—the disclosure of financial conflicts of interest—while necessary, is not sufficient for addressing and neutralizing corporate strategies of influence in public health.

Some scholars have, of course, called for interventions beyond disclosure.[8] At least one of these calls comes from a former policymaker—Joshua Sharfstein who previously served as Secretary of Health for Maryland, principal deputy commissioner of the U.S. Food and Drug Administration ("FDA"), and the public health commissioner of Baltimore. He describes a "trend toward accepting disclosure and transparency of financial conflicts of interest as sufficient," and he argues that a "more serious discussion of what roles should be protected from conflicts of interest is overdue," and that, "[f]or certain critical educational, regulatory, and policy development functions, it may be necessary to prohibit financial conflicts of interest entirely."[9] Even more recently, a group of journal editors and scholars of conflicts of interest published an article in the *BMJ*, launching a new series on conflicts of interest

[2]*See* section I *infra* and accompanying notes. For a brief overview, *see also* Jonathan H. Marks, The Perils of Partnership in Public Health (June 30, 2019), https://conwayhall.org.uk/event/the-perils-of-partnership-in-public-health/ (last accessed May 1, 2020).

[3]*See, e.g.*, NICHOLAS FREUDENBERG, LETHAL BUT LEGAL: CORPORATIONS, CONSUMPTION, AND PROTECTING PUBLIC HEALTH (2014); MARKS, *supra* note 1; Jonathan Gornall, *Sugar: Spinning a Web of Influence*, 350 BMJ h231 (2015).

[4]Ilona Kickbusch et al., *The Commercial Determinants of Health*, 4 LANCET GLOBAL HEALTH e895, e895 (2016).

[5]Daniel S. Goldberg, *The Shadows of Sunlight: Why Disclosure Should Not Be a Priority in Addressing Conflicts of Interest*, 12 PUB. HEALTH ETHICS 202 (2019).

[6]SERGIO SISMONDO, GHOST-MANAGED MEDICINE: BIG PHARMA'S INVISIBLE HANDS 20-24 (2018).

[7]DAVID MICHAELS, DOUBT IS THEIR PRODUCT: HOW INDUSTRY'S ASSAULT ON SCIENCE THREATENS YOUR HEALTH 45-60 (2008) [hereinafter DOUBT IS THEIR PRODUCT]; DAVID MICHAELS, THE TRIUMPH OF DOUBT: DARK MONEY AND THE SCIENCE OF DECEPTION (2020) [hereinafter THE TRIUMPH OF DOUBT].

[8]*See generally* MARKS, *supra* note 1; Daniel S. Goldberg, *supra* note 5, at 209-11; Joshua M. Sharfstein & Yngvild Olsen, *Lessons Learned from the Opioid Epidemic*, 322 JAMA 809 (2019).

[9]Sharfstein & Olsen, *supra* note 8, at 810.

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

and calling for a shift from transparency to independence.[10] But current policymakers have yet to respond to such calls.

In order to address the systemic strategies of influence employed by a variety of sectors of industry in public health contexts, policymakers need to develop comprehensive counterstrategies. To support that claim, I outline here a very brief history of corporate influence in public health, which puts the current pervasive influence in context. I also review the main legal and policy responses, and describe the limitations of the current paradigm. In particular, I address the limitations of characterizing corporate influence as financial conflicts of interest that merely need to be disclosed. I further claim that corporate influence can be *illuminated but not eliminated* by transparency and, in particular, by the disclosure of financial conflicts of interest. Finally, I highlight the kinds of legal and policy responses that will be necessary to effectively address the pervasive corporate strategies of influence that we are currently experiencing.

I. A (VERY BRIEF) HISTORY OF CORPORATE INFLUENCE IN PUBLIC HEALTH

For as long as corporations have existed, they have attempted to influence consumers. Their survival depends on persuading customers to buy their goods and services. But many of the corporate strategies of influence that we know today go far beyond efforts to sway consumers. Such strategies were largely developed and refined in the latter half of the twentieth century. As I cannot fully chart this development in a few paragraphs, I will touch on some notable highlights instead. By many accounts, the corporate strategies of influence we know today were first developed in the 1950s by the tobacco industry, which was trying to cast doubt on the growing body of evidence demonstrating the individual and public health hazards of tobacco.[11] These companies recognized that comprehensive strategies were necessary, and that they would require building relationships with government, the academy, and civil society.[12] The origins of so-called "key opinion leaders," physicians hired by drug companies to deliver scripted promotions of new pharmaceuticals to their peers, have also been traced back to this time period.[13]

Developing alongside tobacco and drug company strategies were food industry strategies. The sugar industry sponsored a research program in the 1960s and 1970s to cast doubt on the health hazards of sucrose and identify fat as the dietary "culprit" in coronary heart disease.[14] Industry funding of studies on the relationship between diet and blood cholesterol also began in the 1970s—and continues to this date, with much of that funding now coming from the egg industry.[15] Food industry strategies were not confined to funding favorable research. For example, one major

[10]Ray Moynihan et al., *Pathways to Independence: Towards Producing and Using Trustworthy Evidence*, 367 BMJ, no. I6576, at 1 (2019).

[11]*See, e.g.*, THE TRIUMPH OF DOUBT, *supra* note 7, at 15-21.

[12]*Id.* at 15-26.

[13]SISMONDO, *supra* note 6, at 112-13, 136-37.

[14]*See, e.g.*, Cristin E. Kearns et al., *Sugar Industry and Coronary Heart Disease Research: A Historical Analysis of Internal Industry Documents*, 176 JAMA INTERNAL MED. 1680, 1681-82 (2016); Cristin Kearns et al., *Sugar Industry Influence on the Scientific Agenda of the National Institute of Dental Research's 1971 National Caries Program: A Historical Analysis of Internal Documents*, 12 PLOS MED. e1001798 (2015).

[15]Neal D. Barnard et al., *Industry Funding and Cholesterol Research: A Systematic Review,* 20 AM. J. LIFESTYLE MED., no. 10, 2019, at 1.

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

company sought to persuade "mothers" to buy its margarine, instead of butter, by building relationships with and influencing (among others) health professionals and consumer groups.[16]

Corporate influence in medicine began to garner the attention of a few physicians and scholars by the early to mid-1980s. In 1980, Arnold Relman, then Editor of the *New England Journal of Medicine*, reminded physicians that medicine and public health have not always been flush with corporate funding.[17] He warned readers about the new "medical-industrial complex," an echo of the concerns President Eisenhower expressed two decades earlier about the "military-industrial complex."[18] Relman later also expressed concern that, in medicine, relationships with drug and device manufacturers had become "more pervasive, complex, and problematic."[19]

Some scholars attribute corporate influence in research to the Bayh-Dole Act of 1980, which created an incentive for universities to commercialize the products of their research by allowing universities to retain title to inventions resulting from federally-funded research programs.[20]

The 1980s and 1990s were also witness to a proliferation of disputes between academic researchers and the industry sponsors of their research.[21] In these high-profile cases, sponsors exerted pressure on researchers (often to behave in ways that were clearly unethical), and the researchers resisted. Such cases were described by some scholars as the "tip of the iceberg."[22] But what lay beneath the surface was arguably more insidious—the systemic problem of subtle or tacit corporate influence and acquiescence on the part of many other industry-funded researchers.[23] The high-profile disputes also revealed a related problem—academic institutions failing to support researchers for fear of alienating corporate donors.[24]

To document the developments in any one sector would require a book—or series of books. In *Ghost-Managed Medicine* (2018), for example, Sergio Sismondo provides evidence that the practice of "ghost writing" journal articles was viewed too narrowly when it began to attract attention in the 1990s and early 2000s. The term was usually understood to refer to the drug company practice of writing articles and then

[16]Bart Penders & Annemiek P. Nellis, *Credibility Engineering in the Food Industry: Linking Science, Regulation, and Marketing in a Corporate Context*, 24 SCIENCE IN CONTEXT 487, 505-08 (2011). *Cf.* Kelly D. Brownell & Kenneth E. Warner, *The Perils of Ignoring History: Big Tobacco Played Dirty and Millions Died. How Similar Is Big Food?*, 87 MILBANK Q. 259 (2009) (comparing the strategies of companies in the food industry with the tobacco industry's successful efforts to influence public health).

[17]Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963, 966-67 (1980).

[18]*Id.* at 963.

[19]Arnold S. Relman, *Dealing with Conflicts of Interest*, 310 NEW ENG. J. MED. 1182, 1182 (1984). *See also* Marc Rodwin, *Physicians' Conflicts of Interest*, 321 NEW ENG. J. MED. 1405 (1989) (articulating concerns about the limitations of disclosure as a way of dealing with conflicts).

[20]Patent & Trademark Law Amendments Act, 96 Pub. L. No. 96-517, §202, 94 Stat. 3015, 3020 (1980).

[21]*See, e.g.*, Arthur Schafer, *Biomedical Conflicts of Interest: A Defense of the Sequestration Thesis—Learning from the Cases of Nancy Olivieri and David Healy,* 30 J. MED. ETHICS 8 (2004). I was counsel for Nancy Olivieri in litigation in the European Court of Justice related to her dispute with the industry sponsor of her clinical drug trials.

[22]Steven Lewis et al., *Dancing with the Porcupine*: *Rules for Governing the University-Industry Relationship*, 165 CANADIAN MED. ASS'N J. 783, 784 (2001).

[23]MARKS, *supra* note 1, at 69.

[24]*See, e.g.*, JON THOMPSON ET AL., THE OLIVIERI REPORT: THE COMPLETE TEXT OF THE REPORT OF THE INDEPENDENT INQUIRY COMMISSIONED BY THE CANADIAN ASSOCIATION OF UNIVERSITY TEACHERS 239-46 (2001).

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

seeking academic authors to sign on to them, often with minimal input.[25] Sismondo's book makes clear that this practice has been part of drug companies' broader strategies of "ghost management." These strategies entail planning the *series* of articles necessary for the approval and promotion of a new drug, finding academics willing to be listed as authors, and trying to place these articles in the best venues.[26]

In her books, *Food Politics* (2007), *Soda Politics* (2015), and *Unsavory Truth* (2018), Marion Nestle has extensively documented the influence of food and soda companies on nutrition research and obesity policy.[27] In his books, *Doubt is Their Product* (2008) and *The Triumpth of Doubt* (2020), David Michaels describes corporate strategies of influence across a variety of industries, among them, tobacco, alcohol, opioids, oil and gas, and football—all designed to cast doubt on science demonstrating the harmful effects of industry products or practices.[28] Corporate strategies not only seek to influence consumers and markets; they also have in their sights government bodies, academic institutions, and civil society groups—as well as the individual members of these entities.[29] These strategies recognize that corporations need to exercise political power, as well as market power, to protect and promote their commercial interests.

The resulting practices have become pervasive. For example, one recent study found two-thirds of patient advocacy groups in the United States received industry funding.[30] Another study painted an even more troubling picture, finding that 83% of the 104 largest patient advocacy organizations receive funding from drug, device, and biotechnology companies.[31] A third recent study reported that two soda companies alone (Coca-Cola and Pepsi) funded close to 100 health-related civil society groups in the United States.[32] What companies call their "penetration" of civil society groups has become so pervasive that it is now difficult—in some cases, almost impossible—to find relevant groups that are independent of industry, and on which policymakers can rely for comments that genuinely reflect the views and interests of patients or the relevant publics.[33] Notably, an investigation into an FDA consultation process (a consultation mandated by statute) revealed that 93% of the participating patient

[25]The often undisclosed drug company authors or consultants hired by the companies are the "ghosts." SISMONDO, *supra* note 6, at 15-16.

[26]In the United States, for the last two decades, these strategies have been coupled with promotional opportunities afforded by direct-to-consumer ("DTC") advertising of prescription drugs. I briefly discuss the history and ethical implications of DTC advertising in the United States in Jonathan H. Marks, *The Price of Seduction: Direct-to-Consumer Advertising of Prescription Drugs in the U.S.*, 64 N.C. J. MED. 292 (2003).

[27]*See generally* MARION NESTLE, FOOD POLITICS: HOW THE FOOD INDUSTRY INFLUENCES NUTRITION AND HEALTH (Univ. of Cal. Press rev. ed. 2013); MARION NESTLE, SODA POLITICS: TAKING ON BIG SODA (AND WINNING) (2015) [hereinafter NESTLE, SODA POLITICS]; MARION NESTLE, UNSAVORY TRUTH: HOW FOOD COMPANIES SKEW THE SCIENCE OF WHAT WE EAT (2018).

[28]*See generally* DOUBT IS THEIR PRODUCT, *supra* note 7; THE TRIUMPH OF DOUBT, *supra* note 7.

[29]*See* MARKS, *supra* note 1, 67-73 (broadly outlining industry strategies to influence academic institutions and civil society groups, as well as governments). *See also* THE TRIUMPH OF DOUBT, *supra* note 7, at 199-216 (providing examples of strategies of influence employed by the food and soda industry).

[30]Susannah L. Rose et al., *Patient Advocacy Organizations, Industry Funding, and Conflicts of Interest*, 177 JAMA INTERNAL MED. 344, 347 (2017).

[31]Matthew S. McCoy et al., *Conflicts of Interest for Patient Advocacy Organizations*, 376 NEW ENG. J. MED. 880, 882 (2017).

[32]David G. Aaron & Michael B. Siegel, *Sponsorship of National Health Organizations by Two Major Soda Companies*, 52 AM. J. PREVENTIVE MED. 20, 21 (2017).

[33]*See* David S. Hilzenrath, *In FDA Meetings, 'Voice' of the Patient Often Funded by Drug Companies*, PROJECT ON GOV'T OVERSIGHT (Dec. 1, 2016), http://pogo.production.vigetx.com/investigation/2016/12/in-fda-meetings-voice-of-patient-often-funded-by-drug-companies [https://perma.cc/3KVW-9HE8].

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

advocacy groups had received funding from industry.[34] Another study in England identified that, in almost four out of every five occasions in which patient advocacy organizations contributed to an appraisal of a medical technology during 2015 and 2016, the organization in question had, in the same year, received funding from the manufacturer of the technology being assessed or a competitor technology.[35] If we make the charitable assumption that policymakers genuinely want access to the views of the relevant publics, untainted by industry, the pervasive nature of corporate influence is making it increasingly difficult to solicit and receive such input in policy and regulatory processes.

II. A (VERY BRIEF) HISTORY OF RESPONSES TO CORPORATE INFLUENCE IN PUBLIC HEALTH

Disclosure of financial relationships with companies—ordinarily framed as financial conflicts of interest—remains the most popular policy response to corporate influence.[36] As I explain more fully elsewhere, there are many avenues for corporate influence, and such influence can exist and prove highly problematic even when there are no financial conflicts of interest.[37] Here, I make the distinct, albeit related, claim that disclosure is *necessary but not sufficient* to address the systemic problem of corporate influence.

In medicine and public health, the conflict of interest definition most frequently employed is the one found in the Institute of Medicine's 2009 report on conflicts of interest in medical research, education, and practice: "a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest."[38] Despite its broad acceptance, several scholars have raised legitimate concerns about this definition. Marc Rodwin cautions that the report's approach to conflicts of interest "neglects the actor's compromised *loyalty* to the party or mission she is supposed to serve" and that, by referring to conflicts between primary and secondary *interests* rather than conflicts between *obligations* and interests, this definition "diminishes the conflict's significance."[39]

My own concerns about the conflict of interest concept encompass, but also go beyond, definitional concerns. In short, corporate influence may result from relationships or practices that may not necessarily give rise to financial conflicts of

[34] *Id.*

[35] Kate L. Mandeville et al., *Financial Interests of Patient Advocacy Organizations Contributing to Technology Assessment at England's National Institute for Health and Care Excellence: Policy Review*, 364 BMJ, no. 5300, at 1 (2019). The study also found that the NICE decision-making committees were aware of fewer than a quarter of the relationships, and that disclosure of almost two-thirds of these relationships was not required by NICE policy.

[36] *See infra* notes 41-47 and accompanying text.

[37] MARKS, *supra,* note 1, at 68-82.

[38] CONFLICTS OF INTEREST IN MEDICAL RESEARCH, EDUCATION, AND PRACTICE 46 (Bernard Lo & Marilyn Field eds., 2009). The definition in this report draws on one by Dennis Thompson, published in the *New England Journal of Medicine* in 1993 in response to growing recognition that the concerns flagged by Arnold Relman in the same journal a decade earlier had become even more problematic. *See* Dennis F. Thompson, *Understanding Financial Conflicts of Interest*, 329 NEW ENG. J. MED. 573, 573 (1993).

[39] Marc A. Rodwin, *Attempts to Redefine Conflicts of Interest*, 25 ACCOUNTABILITY RES. 67, 70 (2018) [hereinafter Rodwin, *Attempts to Redefine Conflicts of Interest*]. Rodwin has also written about the negative effects of disclosure and alternative policy responses. *See* MARC A. RODWIN, CONFLICTS OF INTEREST AND THE FUTURE OF MEDICINE: THE UNITED STATES, FRANCE, AND JAPAN 208-20 (2011); Marc A. Rodwin, *Conflict of Interest in the Pharmaceutical Sector: A Guide for Public Management*, 21 DEPAUL J. HEALTH CARE L. 1, 14-27 (2019).

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

interest. The conflicts of interest framing also tends to lead to an emphasis on individual conflicts and the neglect of institutional conflicts. In addition, the conflicts of interest concept can be exploited to import concerns about "intellectual" conflicts and detract attention from the systemic problem of corporate influence.[40] In this piece, however, I focus on the limitations and potential adverse effects of disclosure of conflicts of interest. To be clear, I am not arguing against disclosure. On the contrary, disclosure in particular and transparency in general should ordinarily be considered the minimum that is ethically required. But we should not allow disclosure to crowd out other legal and policy responses that may be more effective at addressing corporate influence, especially given these limitations and potential adverse effects.

We have seen a proliferation of conflicts of interest disclosure policies in medicine and public health during the last two decades. A study of 1,400 high-impact science journals found that, in 1997, a mere 15.7% of these journals had policies requiring author disclosure of conflicts of interest.[41] By one recent estimate, there are now in excess of 3,100 journals in medicine and health care that are listed by the International Committee of Medical Journal Editors ("ICMJE") as following their policy requiring authors to disclose financial conflicts of interest.[42] A recent analysis of randomized controlled drug trials found disclosures of financial ties between the principal investigator and the manufacturer of the drug in 60% of the trials, and undisclosed ties in a further 8%.[43] Despite the proliferation of both disclosure policies and disclosure itself, there are still significant omissions in the scope, as well as the practice, of disclosure. Notably, two-thirds of U.S. medical journals have not published disclosure policies for editors, even though editor conflicts are widespread—an issue that only recently garnered significant attention in the literature.[44]

Disclosure has also become the policy paradigm in medical education. In 2005, students at Harvard Medical School raised concerns when they discovered that their lecturers were not disclosing financial relationships with the manufacturers of the drugs about which they were lecturing.[45] Two years later, the American Medical Students Association launched its "scorecard," giving grades (from A to F) to medical

[40]*See, e.g.*, MARKS, *supra* note 1, at 23; Jonathan H. Marks, *Lessons from Corporate Influence in the Opioid Epidemic: Toward a Norm of Separation*, 17 J. BIOETHICAL INQUIRY (forthcoming 2020) [hereinafter Marks, *Lessons from Corporate Influence*]. On the third concern, *see also* Rodwin, *Attempts to Redefine Conflicts of Interest*, *supra* note 39, at 73-75.

[41]Sheldon Krimsky, *Journal Policies on Conflict of Interest: If This Is the Therapy, What's the Disease?*, 70 PSYCHOTHERAPY & PSYCHOSOMATICS 115, 116 (2001). Policies are one thing; compliance is quite another. The same study found that of the 220 journals with disclosure policies, only 0.5% of articles had disclosures of conflicts and 66% of the journals had no conflicts of interest disclosures for that year. *Id.*

[42]Rafael Dal-Ré & Ana Marušić, Letter to the Editor, *Are Journals Following the ICMJE Recommendations Complying with Conflicts of Interest Disclosure Policies*, 57 EUR. J. INTERNAL MED. e17, e17 (2018).

[43]Rose Ahn et al., *Financial Ties of Principal Investigators and Randomized Controlled Trial Outcomes: Cross Sectional Study*, 356 BMJ i6770, at 4 (2017). *Cf.* Quinn Grundy et al., *Prevalence of Disclosed Conflicts of Interest in Biomedical Research and Associations with Journal Impact Factors and Altmetric Scores*, 319 JAMA 408, 408-09 (2018) (finding that close to one in four articles published in journals that purport to conform with the ICMJE policy had disclosures of conflicts of interest, but excluding industry funding of the study and industry employment from that assessment).

[44]Dal-Ré & Marušić (2018), *supra* note 42, at e17. *See also* Dal-Ré et al., *Editors' and Authors' Individual Conflicts of Interest Disclosure and Journal Transparency. A Cross-Sectional Study of High-Impact Medical Specialty Journals*, 9 BMJ OPEN, no. 029796, at 1-2 (2019); Waqas Haque et al., *Conflicts of Interest of Editors of Medical Journals*, 13 PLOS ONE, May 2018, at 1, 2; Victoria S. S. Wong et al., *Industry Payments to Physician Journal Editors*, 14 PLOS ONE, Feb. 2019, at 2-9.

[45]Duff Wilson, *Harvard Medical School in Ethics Quandary*, N.Y. TIMES, Mar. 2, 2009, at B1.

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

schools for the existence and content of their conflicts of interest policies.[46] After considerable pressure from medical students, Harvard Medical School subsequently introduced a policy requiring all lecturers to disclose and describe, when relevant, their conflicts of interest at the beginning of their lectures.[47]

Over time, disclosure has become not only the paradigm institutional policy response, but also the dominant legal response. The Physican Payments Sunshine Act of 2010 ("PPSA") (also known as section 6002 of the Affordable Care Act) requires drug and device manufacturers to disclose their payments to physicians and teaching hospitals.[48] Although information about these payments has been made available for several years on a searchable website, the vast majority of patients do not know about the website and, even when they do, they rarely visit it to determine whether their physician has accepted payments.[49] Despite this, lawmakers have continued to build on the disclosure provision. Section 6111 of the SUPPORT Act 2018—drafted in response to the opioid epidemic—expands companies' legal obligation to disclose payments: commencing in 2022, companies will also need to disclose payments they have made to physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse-midwives.[50] The section is optimistically entitled "Fighting the Opioid Crisis with Sunshine."[51] But it will take far more than sunshine to address the opioid crisis and the many other public health challenges to which corporate influence has contributed.

To be clear, I do not oppose the expansion of the categories of payment recipient for which disclosure is required. In addition to those professionals listed in the SUPPORT Act, one might add several others:[52] for example, patient advocacy groups (so many of which receive funding from drug, device, and biotechnology companies) and a range of professionals giving nutrition or dietary advice (many of whom receive gifts from food and soda companies).[53] However, I am concerned about lawmakers' and policymakers' reliance upon disclosure—principally, or worse yet, completely—to address corporate influence. Recent evidence makes clear that compliance with disclosure and enforcement are often woefully inadequate. For example, one study found that one in four writers of practice guidelines had potentially relevant undisclosed ties to the pharmaceutical industry.[54] Even if there were perfect

[46] *AMSA Scorecard*, AM. MED. STUDENT ASS'N, https://www.amsa.org/scorecard [https://perma.cc/64YQ-QXCX]. AMSA abandoned its scorecard in 2018, when it decided to switch its efforts to monitoring conflicts of interest in Congress instead. *See AMSA Takes a Deeper Look into Conflicts of Interest as It Relates to Health Policy*, AM. MED. STUDENT ASS'N (Oct. 15, 2018), https://www.amsa.org/about/amsa-press-room/conflicts-of-interest-relates-to-health-policy [https://perma.cc/R3GD-8EEU].

[47] *See* Wilson, *supra* note 45.

[48] Physician Payments Sunshine Act of 2010, Pub. L. No. 111-148, § 6002, 124 Stat. 689.

[49] Genevieve P. Kanter et al., *Effect of the Public Disclosure of Industry Payments Information on Patients: Results from a Population-Based Natural Experiment*, 2019 BMJ OPEN, no. 024020, at 3 (2019).

[50] SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018).

[51] §6111, 132 Stat. at 4006-07.

[52] A recent study revealed that, in Australia, clinicians who receive payments from industry include nurses, physical therapists, and dietitians. *See* Emily A. Karanges et al., *Understanding the Nature and Extent of Pharmaceutical Industry Payments to Nonphysician Clinicians*, 179 JAMA INTENERAL MED. 1430, 1430-32 (2019). There is good reason to anticipate similar practices especially among multinational drug companies in the United States.

[53] *See, e.g.*, NESTLE, SODA POLITICS, *supra* note 27, at 252-56; Marks, *Lessons from Corporate Influence*, *supra* note 40.

[54] Ray Moynihan et al., *Undisclosed Financial Ties Between Guidelines Writers and Pharmaceutical Companies: A Cross-Sectional Study Across 10 Disease Categories,* 9 BMJ OPEN, no. 025864, at 4-6 (2019).

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

compliance with disclosure requirements, there are compelling arguments that disclosure alone is insufficient—not only for the writers of practice guidelines, but also more broadly in medicine and public health.[55]

III. ON THE LIMITS OF DISCLOSURE OF CONFLICTS OF INTEREST

Before developing a theoretical critique of conflicts of interest disclosure, I briefly review the empirical research on disclosure. Much of this research has historically involved one-shot (rather than multiple-round) experiments—often using student and other non-professional participants who are engaged in role-play.[56] Some more recent evidence comes from experiments involving professionals (including health professionals) and from observational work in the field.[57] As the analysis below makes clear, the findings on the effects of disclosure are somewhat mixed.

The first challenge in discussing the research on disclosure is to be clear about the relevant parties. For scholars already familiar with the substantial behavioral science literature on disclosure, I will build on terminology often employed in that research while noting its limitations. Although I expand on these concerns below, they can be put briefly. First, the advisor/advisee frame evokes a dyad (or, at best, a triad), but, in reality, corporate influence is best viewed as a web of relations. Second, the terms do not readily conjure at least two kinds of relationships in which disclosure may also be problematic: intra-professional and institutional relationships.

Given that the principal concern underpinning much of the social science research is whether the receipt of payments may create bias in the advice of professional advisors (e.g., financial advisors advising clients, or physicians advising patients), studies often employ the term "*advisor*."[58] In many of these studies (as I have noted), however, the advisors are not actual professional advisors but students engaged in role-play—constituting what social scientists characterize as "convenience samples."[59] When using the term "advisor," we should keep in mind not only the paradigmatic cases of physicians and other health professionals, but also of scientists and other academics. These experts often act in advisory roles—for example, giving congressional testimony, serving on advisory boards, and drafting guidelines (whether clinical practice guidelines, dietary guidelines, or some other kind of guidance).[60] In addition, they engage in other scholarly activities, including conducting research and

[55] *See* discussion *infra* Sections III.A, III.B, III.C, and IV.

[56] *See, e.g.*, Daylian M. Cain et al., *The Dirt on Coming Clean: Perverse Effects of Disclosing Conflicts of Interest*, 34 J. LEGAL STUD. 1, 9 (2005), and Bryan K. Church & Xi (Jason) Kuang, *Conflicts of Interest, Disclosure, and (Costly) Sanctions: Experimental Evidence,* 38 J. LEGAL STUDIES 505, 513-4 (2009).

[57] *See, e.g.*, Leslie K. John et al., *Effect of Revealing Authors' Conflicts of Interest in Peer Review: Randomized Control Trial,* 367 BMJ, no. 5896, at 1 (2019).

[58] *See, e.g.*, Sunita Sah & George Lowenstein, *Nothing to Declare: Mandatory and Voluntary Disclosure Leads Advisors to Avoid Conflicts of Interest* 25 PSYCHOL. SCI. 575, 575 (2014).

[59] John et al., *supra* note 57, at 1-2 (using the term "convenience sample" in the discussion of a study that deliberately avoids using such a sample) .

[60] *See, e.g.*, Tim Schwab, *U.S. Opioid Prescribing: The Federal Government Advisers with Recent Ties to Big Pharma*, 366 BMJ I5167 (2019) (expressing concern that members of panels convened by the National Academies of Science, Engineering, and Medicine, including one commissioned to advise policymakers on clinical practice guidelines for prescribing opioids, had received payments from opioid companies), and Michael J. Hayes & Vinay Prasad, *Financial Conflicts of Interest at FDA Drug Advisory Committee Meetings*, 48 HASTINGS CTR. REP. 10 (2018) (discussing conflicts of interest among voting members and invited expert speakers at meetings of the Oncologic Drugs Advisory Committee).

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

reporting their findings in scholarly journals. Although this would not ordinarily be considered providing advice, we should clearly be concerned about the impact of scientists' financial relationships with the industry sponsors of their research—especially given the ways in which such relationships influence not only research findings and the interpretation of those findings, but also the very questions that scientists explore and ignore.[61]

In addition to individuals, when thinking about the "advisor," we should keep institutions in mind, whether or not those institutions are engaged in activities that would ordinarily be considered advisory. Consider, for example, patient advocacy organizations making representations in regulatory or policy-making processes. There is a growing body of evidence that such groups frequently participate in policy processes without disclosing their financial relationships with industry.[62] Other relevant institutions include health professional associations, teaching hospitals/academic medical centers, and research universities. Even when they are not engaged in activities that might ordinarily be considered advisory, these entities are engaging in activities on which others rely, and we should be concerned about the impact of their financial relationships on those activities. Reliance on so-called "advisors" may be either specific or general. As an example of the latter, we, as a society, depend on universities to generate unbiased and credible research.[63]

Similarly, we should also think about "*advisees"* broadly. We miss relationships of concern if we focus only on individual patients receiving advice from their doctors. Just as researchers are "advisors" of concern, we should also conceptualize advisee to include those who rely on research and recognize that some of these individuals may also be professionals. Two examples of this would be the peer reviewer of an article submitted to a scholary journal,[64] and a physician reading and considering whether to rely upon a study published in that journal.[65] But, like advisors, advisees may also be institutional. So, for example, when the Centers for Disease Control and Prevention ("CDC") received representations from various patient advocacy organizations that did not disclose their industry funding when opposing the CDC's draft guidelines on opioid prescribing,[66] the CDC was effectively an advisee with regard to those representations. But the CDC is also, of course, an advisor in the drafting, revising, and issuing of those guidelines. So these categories are not mutually exclusive.

The third term I would add to this model is my own: *influencer.* This would include, for example, drug and device manufacturers and food and soda companies. It would also encompass their trade associations. The literature on disclosure tends to

[61]*See, e.g.,* MARKS, *supra* note 1, at 68-71.

[62]*See, e.g.*, Marks, *Lessons from Corporate Influence*, *supra* note 40 (discussing a 2018 congressional report by the Minority Staff of the U.S. Senate Homeland Security & Governmental Affairs Committee on the financial relationships between patient advocacy groups and the opioid industry).

[63]*See, e.g.*, INSTITUTE OF MEDICINE, ON BEING A SCIENTIST: A GUIDE TO RESPONSIBLE CONDUCT IN RESEARCH 2-3 (2009).

[64]*See* John et al., *supra* note 57, at 1-2 (discussing the range of reviewers studied in prior conflict of interest disclosure studies).

[65]For a study exploring the impact of funding disclosures on physicians, *see* Aaron S. Kesselheim et al., *A Randomized Study of How Physicians Interpret Research Funding Disclosures*, 367 NEW ENG. J. MED. 1119 (2012).

[66]For the 2016 CDC guideline for opioid prescription for chronic pain and a summary of its development, *see* Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016*, 65 RECOMMENDATIONS & REP. 1, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm [https://perma.cc/9CU5-UGMY].

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

look only at payments as a form of influence.[67] But it is important to recognize that influence may also result from "in-kind" contributions—whether goods (such as free drug samples), services (such as displaying the government's MyPlate icon on food packaging), or anything else of value to the recipient. Moreover, it is important to recognize that these influencers, which we might consider *originating* influencers, create webs of influence that turn many of the advisors and advisees discussed above into co-influencers. Both points are notable given that the studies on disclosure tend to focus only on originating influencers and on financial payments as a means of exercising that influence.

What dyad and triad-based models of disclosure also omit is that additional parties may be affected by the influence and advice.[68] When the influencer is an opioid company, and the advisor is a health professional association or some other advisory body producing opioid prescribing guidelines for doctors, the advisees are doctors. The missing party in such models is patients, who are clearly affected. Lawyers would call them third parties—although in the case of a triad of advisor, advisee, and influencer, that term does not fit well. And, as those third parties—whether patients, communities, or populations—are often the very people whose interests we should be most concerned about protecting, an additional concern is that the term third party may threaten to relegate rather than prioritize their interests and wellbeing.[69]

Finally, I do *not* refer to "disclosers" as a distinct category because disclosers of conflicts of interest—or the underlying gifts or relationships—may be influencers, advisors, third parties (a less troubling usage in this context), or some combination thereof. In the case of the PPSA, the obligation to disclose is placed on influencers, the drug and device companies.[70] In contrast, the guidelines of the ICMJE place the obligation to disclose on authors—advisors for the purpose of the schema in the disclosure literature.[71] But authors (and, for that matter, speakers) may also be asked to disclose payments to others with whom they have personal or professional relationships—for example, their domestic partners or the institutions that employ them.[72] Where the obligation falls can be significant: some professionals might avoid conflicts they are required to disclose themselves, but they would be less troubled by the same conflicts if only the *influencer* were required to disclose them (especially when no one else pays attention to the disclosure.) For this reason, we should be attentive to the identity of the discloser, both in experiments and in the real world.

A. IMPACT ON BEHAVIOR OF THE ADVISOR

1. On the Advice

[67]For a brief discussion of other possible forms of influence, *see* MARKS, *supra* note 1, at 153.

[68]I offer a more detailed critique of dyad and triad-based accounts of corporate influence in MARKS, *supra* note 1, at 7–9.

[69]*Id.* at 65.

[70]42 U.S.C. § 1320a-7h (2018).

[71]*See* INT'L COMM. MED. JOURNAL EDITORS, RECOMMENDATIONS FOR THE CONDUCT, REPORTING, EDITING, AND PUBLICATION OF SCHOLARLY WORK IN MEDICAL JOURNALS 3-4 (2019), http://www.icmje.org/icmje-recommendations.pdf [https://perma.cc/WGF4-KSRN] (last accessed May 31, 2020).

[72]*See, e.g.*, ICMJE Form for Disclosure of Potential Conflicts of Interest, http://www.icmje.org/conflicts-of-interest/ [https://perma.cc/8DUY-ZRBF] (last accessed May 31, 2020) (requiring authors to disclose "all sources of revenue paid (or promised to be paid) directly to you or your institution on your behalf over the 36 months prior to submission of the work.")

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

One of the central concerns about financial conflicts of interest arising from relationships with industry is the impact on the behavior of professionals—especially, biased advice. Several social scientists have explored whether disclosure of conflicts of interest might alleviate this impact.[73] The empirical data, while mixed, suggests that it would be a mistake to rely on disclosure for this effect. A central concern first raised by the social science research is that disclosure can lead to *strategic exaggeration*. In other words, bias in the advice may *increase* substantially when the advisor's conflict is disclosed.[74] This is even more worrying when the recipient of the disclosure does not sufficiently discount the advice in order to counteract the increased bias or does not have the opportunity or resources to seek independent advice. The advisor's bias may be inflated not only to anticipate discounting, but also in the belief that the advisee has been warned or put on notice about the conflict of interest.[75] Having disclosed their conflicts of interest, advisors may also feel at greater liberty to "gild the lily," believing that they have put the advisee on notice—this is what some scholars call "moral licensing."[76] A more recent series of studies, on the other hand, suggests that disclosure can make professional norms more salient, and increase the quality of advice given by the professional advisors.[77] But this research should not be read as a ringing endorsement of disclosure as an antidote to bias; notably, the author of the studies, Sunita Sah, expressly argues otherwise.[78] We should also keep in mind that, in Sah's studies, the advisors disclosed their own conflicts.[79] In contrast, the PPSA does not require physicians to disclose payments from industry; the obligation is instead imposed on drug and device companies.[80] Although other scholars found some evidence of a decrease in prescribing of brand drugs by salaried physicians' in the wake of Massachusetts' disclosure law (an effect the authors attribute to "social image" concerns), the study did not find such an effect in relation to physicians who received larger payments.[81] In addition, as scholars of disclosure have been aware for some time, physicians with financial interests in medical facilities tend to recommend more (or more expensive) tests even when they have been required to disclose those interests.[82]

Other real-world evidence suggests that we should not rely on disclosure to improve the quality of science, or to address scientific bias associated with industry

[73]For research suggesting that disclosure can have the opposite effect, *see e.g.*, Daylian M. Cain et al., *The Dirt on Coming Clean: Perverse Effects of Disclosing Conflicts of Interest*, 34 J. LEGAL STUD. 1 (2005); George Loewenstein et al., *The Unintended Consequences of Conflict of Interest Disclosure*, 307 JAMA 669 (2012).

[74]Cain et al., *supra* note 73, at 6-8; Loewenstein et al., *supra* note 73, at 669.

[75]George Loewenstein et al., *The Limits of Transparency: Pitfalls and Potential of Disclosing Conflicts of Interest*, 101 AM. ECON. REV. 423, 424-25 (2011).

[76]*See* Cain et al., *supra* note 73, at 7.

[77]Sunita Sah, *Conflict of Interest Disclosure as a Reminder of Professional Norms: Clients First!,* 154 ORG. BEHAV. HUM. DECISION PROCESSES 62 (2019). Making professional norms more salient is, of course, not inherently good. The ethics of promoting norm salience will depend on the nature and content of those norms. For example, norms that promote self-interest among advisors are clearly far more problematic than norms that promote the interests of fiduciaries whose interests the advisors have an obligation to protect.

[78]*See id.* at 75-77.

[79]*Id.* at 66-75.

[80]42 U.S.C. § 1320a-7h (2018).

[81]Matthew Chao & Ian Larkin, Regulating Conflicts of Interest Through Public Disclosure: Evidence from a Physician Payments Sunshine Law 9 (Oct. 1, 2017) (unpublished manuscript); *see also* Tong Guo et al., Let the Sun Shine in: The Impact of Physician Payment Disclosure on Physician Prescribing Behavior 2 (2017, rev. Feb. 25, 2019) (unpublished manuscript).

[82]*See* Rodwin, *supra* note 19, at 1406.

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

funding. A recent *Cochrane Review* found not only that industry-funded research produces more favorable outcomes for industry sponsors, but also that "industry sponsored studies had less concordance between results and conclusions compared with non-industry sponsored studies."[83] So disclosure of conflicts of interest is clearly not improving the "quality" of biomedical science—as evidenced by the fact that the industry funding of the studies in the *Cochrane Review* was disclosed. Whether the context is medical practice, biomedical science, or public health, as Sah notes, the elimination of conflicts is "likely to have a much larger effect on improving advice quality" than disclosure.[84]

2. On the Advisor's Receipt of Gifts/Payments

Some scholars have argued that the prospect of disclosing a conflict could discourage physicians from entering into relationships that are difficult to justify.[85] There is some evidence from lab experiments that the mandatory disclosure of conflicts of interest can lead to the avoidance of those conflicts, provided that such conflicts are perceived as *avoidable*.[86] In the field, however, the evidence is mixed.[87] In some cases, the implementation of a disclosure policy may be followed by an *increase* in conflicts.[88] One potential explanation for this phenomenon is *social proof*; in short, physicians decide what to do by looking at what others are doing.[89] When conflicts are pervasive and professionals observe that many of their peers have them, they may perceive these relationships as acceptable, even desirable. Notably, the PPSA, which places an obligation on drug and device companies—but not on physicians—to disclose the payments, does not appear to have had a significant impact on physicians' willingness to accept industry gifts.[90] The Open Payments website indicates that total annual payments between 2014 and 2018 have increased from $8.58 billion to $9.23 billion.[91] The total number of payments exceeded 11 million each year in 2014 to 2017, and dipped only slightly to 10.82 million for 2018.[92] More fine-grained analyses similarly suggest disclosure has not reduced physicians' willingness to accept gifts from industry. One recent study found that, on average,

[83]Andreas Lundh et al., *Industry Sponsorship and Research Outcome*, 2 COCHRANE DATABASE OF SYSTEMATIC REVIEWS, no. MR000033, 2017, at 22. For another example of a study finding evidence of what I call the "interpretation gap," *see also* Barnard et al., *supra* note 15, at 7.

[84]Sunita Sah & Daniel Feiler, *Conflict of Interest Disclosure with High-Quality Advice: The Disclosure Penalty and the Altruistic Signa*l, 26 PSYCHOL., PUB. POL'Y, L. 88, 102 (2020).

[85]*See* Sunita Sah & George Loewenstein, *Nothing to Declare: Mandatory and Voluntary Disclosure Leads Advisors to Avoid Conflicts of Interest*, 25 PSYCHOL. SCI. 575, 576 (2014). The authors made this claim in earlier work too. *See also* Loewenstein et al., *supra* note 73, at 670.

[86]*See* Sah & Lowenstein, *supra* note 85, at 576-82.

[87]*See* Michael Sinha & Aaron Kesselheim, *The Effects of the Sunshine Act: What Can and What Should We Expect?*, 17 AM. J. BIOETHICS 22, 22-23 (2017).

[88]*See, e.g.*, Lisa Cosgrove & Sheldon Krimsky, *A Comparison of DSM-IV and DSM-5 Panel Members' Financial Associations with Industry: A Pernicious Problem Persists*, PLOS MED. 9(3): e1001190, at 1 (2012); *see also* Lisa Cosgrove et al., *Developing unbiased diagnostic and treatment guidelines in psychiatry*, 360 N ENG. J MED. 2035, 2036 (2009).

[89]*See, e.g.*, Sunita Sah & Adriane Fugh-Berman, *Physicians under the Influence: Social Psychology and Industry Marketing Strategies*, 41 J. L. MED. & ETHICS 665, 669 (2013) (drawing on the work of Robert Cialdini).

[90]For a focus group study (conducted in 2015) exploring physicians' views of the PPSA, *see* Susan Chimonas et al., *Bringing Transparency to Medicine: Exploring Physicians' Views and Experiences of the Sunshine Act*, 17 AM. J. BIOETHICS 4 (2017).

[91]*The Facts About Open Payments Data*, CMS.GOV, https://openpaymentsdata.cms.gov/summary [https://perma.cc/UF2Q-B6BA] (last accessed Apr. 21, 2020).

[92]*Id.*

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

there was no significant change in monthly payments to 50,000 physicians in relation to 16 anti-diabetes brand drugs in the 15-month period following the PPSA coming into effect.[93] The authors concluded that "public pressure . . . if there is any, seems to be ineffective" at reducing physician payments.[94] They also observed that disclosure may be "especially ineffective towards more expensive drugs and heavier prescribers"[95]—arguably, the cases of greatest concern.

B. IMPACT ON ADVISEES

Much of the empirical literature explores the impact of disclosure of physicians' conflicts of interest on patients. But, as noted above, it is important to keep in mind that patients are not the only potential "advisees" in medicine and public health. Others include: health professionals reading conflicts of interest disclosures made by peers in scholarly journals;[96] public health agencies receiving representations (and disclosures, when made) from patient advocacy organizations; and physicians, patients, and others who read the reports of advisory committees (including committees drafting practice guidelines). The potential impacts and, in turn, the pitfalls of disclosure are likely to vary considerably depending on the context and audience.

The evidence on disclosure of conflicts of interest to patients raises significant concerns. One recent study notably concluded that the Open Payments Database, created pursuant to the PPSA, "has fallen well short of its aspiration to better inform patients of their physicians' industry relationships."[97] The study found that, two years after the launch of the Open Payments website, only 13% of respondents knew that information about their physician's receipt of payments was available; worse still, only 3% knew whether their own doctor had received payments.[98] Another recent study found that mailing disclosure of physician conflicts directly to patients with their appointment letter was effective at informing only 57% of recipients of their physician's conflict of interest—disturbingly, 43% of respondents did not understand it, ignored it, or forgot it.[99] So approaches to disclosure, thus far, do not appear to be serving their intended function: to inform patients of their doctors' conflicts.

Second, if patients receive the disclosure, do they understand the implications of the conflict? And, if so, what impacts does it have on their perceptions and beliefs? There is mixed evidence on the impact of conflicts of interest disclosure on patient trust. In a study at the Cleveland Clinic, the disclosure of physicians' conflicts of interest in the appointment letter did not significantly impact patient trust in the physician or hospital.[100] However, another recent study found that public disclosure of

[93]Tong Guo et al., The Effect of Information Disclosure on Industry Payments to Physicians (2017, rev. Aug. 6, 2019) (unpublished manuscript).

[94]*Id.* at 5.

[95]*Id*.

[96]On the impact of disclosure on physicians, *see* Kesselheim et al., *supra* note 65 (finding that disclosure of funding in research studies undermined the trust of health professionals—they were less willing to rely on those studies).

[97]Genevieve P. Kanter et al., *Effect of the Public Disclosure of Industry Payments Information on Patients: Results from a Population-Based Natural Experiment*, 9 BMJ OPEN, no. 024020, 2019, at 3.

[98]*Id.*

[99]Susannah L. Rose et al., *Patient Responses to Physician Disclosures of Industry Conflicts of Interest: A Randomized Field Experiment*, ORG. BEHAV. & HUM. DECISION PROCESSES, at 9 (2019), https://doi.org/10.1016/j.obhdp.2019.03.005 [https://perma.cc/BA84-UR95] (last accessed May 31, 2020). This assumes, as the authors note, that the patients received and opened the letter.

[100]*Id*. The study found that uncertainty about the existence of conflicts of interest created more distrust than knowing about the conflict. *Cf.* Sah & Feiler, *supra* note 84 (finding that disclosure of conflicts

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

payments to physicians was associated not only with decreased trust in the medical profession, but also with decreased trust in one's own physician—irrespective of whether the respondent knew that their physician had received payments.[101] In contrast, a further group of studies alarmingly suggests that disclosure can *increase* trust in an advisor's expertise and, in turn, can enhance their persuasiveness—especially when the advisee does not deliberate about the disclosure or has not been given the opportunity to do so.[102]

Patients may not know what to do with the disclosure and may simply ignore it.[103] But if patients understand the disclosure and its implications for medical practice, and they are able to assimilate this information into their decision-making process, a third and related question remains: are they willing and able to act on it? There is some evidence that patients receiving disclosures from their physicians may experience distrust and, at the same time, feel pressure to follow their physician's advice or recommendations. This may be due to their fear of signaling distrust to their doctor—what some scholars call "insinuation anxiety."[104]

Even absent insinuation anxiety, the question remains: do patients have the financial and temporal resources to act on the information? The participants in the Cleveland Clinic study did not change their appointments when they received the conflicts of interest disclosure with their appointment letter.[105] This is hardly surprising given the time costs of canceling their appointment and finding an alternative physician. The outcome might have been different, however, if patients had been given the information at the time of *choosing the physician*—if someone had explained to them in person the impact of conflicts of interest on medical advice, and if they had been offered an appointment with another physician with similar experience and expertise who did not have financial conflicts of interest. As some scholars of disclosure have observed, it is arguably perverse to place the burden of interpreting and responding to disclosure on patients, especially given their general lack of knowledge of the social science research on bias that would make clear why the relationships being disclosed are problematic.[106] Moreover, if disclosure is the sole, or primary, measure to address physician conflicts of interest, this imposes the burden of addressing a systemic problem on individuals who are not only ill-equipped to address

---

of interest may result in a *disclosure penalty*, but that the effect of the penalty may be muted if the presence of the advisor's conflict is perceived as systemic or beyond the advisor's control, and not reflective of the advisor's character).

[101]Genevieve P. Kanter et al., *US Nationwide Disclosure of Industry Payments and Public Trust in Physicians,* 2 JAMA NETWORK OPEN, no. 2, Apr. 2019, at 1.

[102]*See* Sunita Sah et al., *Conflict of Interest Disclosure as an Expertise Cue: Differential Effects of Automatic and Deliberative Processing*, 147 ORG. BEHAV. & HUM. DECISION PROCESSES 127, 128, 143-45 (2018).

[103]For an early articulation and exploration of this concern, *see* George Loewenstein et al., *The Limits of Transparency: Pitfalls and Potential of Disclosing Conflicts of Interest*, 101 AM. ECON. REV. 423, 424 (2011). For more recent empirical work on this question, see Rose et al., *supra* note 99.

[104]Sunita Sah et al., *Insinuation Anxiety: Concern that Advice Rejection Will Signal Distrust After Conflict of Interest Disclosures*, 45 PERSONALITY & SOCIAL PSYCH. BULL. 1099, 1100 (2019) (also finding that insinuation anxiety may be diminished when disclosure is made by an external sources rather than by the advisor directly.) *See also* Sunita Sah, *Why Humans Find it so Hard to Resist Taking Bad Advice*, L.A. TIMES (Oct. 22, 2019, 6:50 AM), https://www.latimes.com/opinion/story/2019-10-29/advice-neuroscience-psychology-social-pressure-research [https://perma.cc/XT8U-TGYX]. This work builds on Loewenstein et al., *supra* note 75, at 424-26; and Loewenstein et al., *supra* note 73, at 670.

[105]Rose et al., *supra* note 99, at 607.

[106]*See* Genevieve P. Kanter & George Loewenstein, *Evaluating Open Payments*, 322 JAMA 401, 401-02 (2019).

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

it, but are also being harmed by it—and, for compelling evidence of harm, we need look no further than the opioid crisis.[107]

As noted above, "advisees" may not only be patients. A recent study explored the impact of disclosures of authors' financial conflicts of interest on peer reviewers for a medical journal.[108] The study found that the disclosures had no impact on the reviewers' mean ratings of manuscript quality.[109] But the authors of the study rightly flagged that it is not clear how reviewers should address such a disclosure: "If a disclosure reveals an important [conflict of interest], should the reviewer recommend rejection? Apply special scrutiny to methods? Consult additional experts? No consensus exists about how reviewers should respond to . . . disclosures; nor, hence, is any direction provided about how to do so."[110] Although the authors suggest that the editor could enlist a "highly qualified methodologist" or another reviewer to evaluate manuscripts with serious conflicts of interest, the authors conclude that—at least in its current form—"disclosure does not provide the long desired tool for solving the problems created by conflicts."[111]

C. IMPACT ON THE INFLUENCER

Disclosure of conflicts of interest may have an impact on the corporate entity trying to exercise influence. In theory, disclosure could result in increased giving. One company may wish to outbid its competitors. Alternatively, it could encourage corporations to be more strategic in their giving and "fine-tune" their marketing efforts.[112] In some cases, disclosure might lead to the withdrawal of funding. Notably, in the wake of the U.S. Senate report on opioid industry funding of several patient advocacy groups and professional societies related to pain management, some opioid companies withdrew funding.[113] Companies may have done so because they were concerned that these entities would now be perceived as "front groups" for industry,[114] and that the influence of these groups—and, in turn, their own indirect influence through these groups—would be diminished as a result of the exposure and resulting criticism. Corporate funding of these kinds of groups, however, remains pervasive.[115] And there is no evidence that the pharmaceutical industry more broadly has pulled away from interactions with civil society groups as a form of influence. There is also little evidence to suggest that the mandated disclosure of industry payments to physicians has had a chilling effect on pharmaceutical companies' willingness to make gifts. As mentioned above, the Open Payments database reveals that gifts have not diminished in the last four years: roughly $9 billion across 11 million transactions.[116]

---

[107]Marks, *Lessons from Corporate Influence*, *supra* note 40 (examining the role of corporate influence in the opioid epidemic, and reviewing evidence that physicians' interactions with opioid sales "reps" are associated with increased opioid prescribing and higher rates of overdose deaths). While patients are clearly ill-equipped, even professionals and public health agencies may have difficulty knowing how to respond to conflicts disclosures, an issue I address in the next paragraph.

[108]John et al., *supra* note 57.

[109]*Id.* at 6.

[110]*Id.* at 9.

[111]*Id*.

[112]Kanter & Loewenstein, *supra* note 106, at 402.

[113]Marks, *Lessons from Corporate Influence*, *supra* note 40.

[114]*See* THE TRIUMPH OF DOUBT, *supra* note 7, at 261-62.

[115]*See generally* McCoy et al., *supra* note 31; Rose et al., *supra* note 30; Aaron & Siegel, *supra* note 32.

[116]*See The Facts About Open Payments Data*, *supra* note 91.

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

IV. MOVING BEYOND DISCLOSURE

Although the empirical research on disclosure is extremely valuable, it is important to go beyond this analysis and consider the ways in which disclosure does not address systemic and institutional problems. When all or most practitioners or researchers working in a particular field receive money from drug companies, it may be difficult or impossible to find truly independent advice. At an institutional level, corporate influence may be even more problematic. I have already argued that corporate funding of patient advocacy groups undermines the ability of policymakers to have access to the views and interests of patients that are truly independent of the views of industry actors operating in the same space.[117] But when the authors of guidelines—whether clinical practice guidelines, dietary guidelines, or some other form of professional guidance—have financial conflicts of interest, this is especially problematic and disclosure is clearly inadequate.[118] Surely, what professionals, patients, and society need are guidelines from which the risk of bias associated with industry relationships has been eliminated. It is also problematic when the entity being influenced is one of a small number of institutions (one of only two or three so-called "centers of excellence" in a particular field) or, perhaps, the only entity that can perform the functions that we as a society rely on it to perform—such as a public health agency at the local, national, or international level. As influence becomes more pervasive, it may lead to the "exhaustion" of independent advisors and advice, and of science and scientists. It becomes almost impossible to find individuals and institutions without financial relationships, and to find research, practice, education, and policy that has not been influenced by such relationships. In addition, the pervasiveness of influence may increase the risks of potential adverse effects of disclosure. When disclosure reveals that relationships with industry are pervasive, it may reinforce the view among the relevant individuals or institutions that these relationships are unavoidable and, therefore, acceptable.[119] Even when relationships are pervasive, certain kinds of relationships with industry may still be characterized as scarce or competitive resources, and they may be perceived as not merely acceptable but desirable.[120]

Several scholars and commentators have emphasized that transparency should only be the first step.[121] For example, De Jong and Steinbrook argue: "The next steps are to move from greater transparency to reforms that . . . diminish the incentives for industry payments to health care professionals in the first place."[122] To this, I would add: we need measures that address the incentives not only for companies to make payments, but also for professionals to accept them; and, beyond removing incentives, we need to consider when prohibitions are warranted. A number of other scholars

[117] *See* discussion *supra* Section I and notes 33-35.

[118] *See* MARKS, *supra* note 1, at 121-39.

[119] *See* Sah & Fugh-Berman, *supra* note 89, at 666-67.

[120] *See id.* at 669-70. The term "key opinion leader" (KOL) is designed to make physicians believe that these are not only financially lucrative positions but also scarce resources, and that being hired as a KOL is a signifier of status.

[121] In addition to the scholarship discussed in this paragraph, *see also* Tracy E. Miller & William M. Sage, *Disclosing Physician Financial Incentives*, 28 JAMA 1424 (1999), in which proponents of disclosure of physician financial incentives recognize that disclosure laws "exemplify regulatory restraint," and that they should support not substitute for substantive regulation that would protect patients from "unreasonable risk." *Id.* at 1429.

[122] Colette DeJong & Robert Steinbrook, *Shining a Light on Industry Payments to Health Care Professionals Who Are Not Physicians,* 179 JAMA INTERNAL MED. 1430, 1433 (2019).

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

argue that, while disclosure is generally "a good thing," it is "no panacea."[123] Koch et al. argue that transparency with regard to physicians' relationships with pharmaceutical companies should be seen as "a stepping-stone rather than an end in itself."[124] Bachynski and Goldberg describe disclosure as an "ethical floor."[125] That metaphor vividly captures the idea that disclosure is necessary but not sufficient. One major concern is that, after disclosure has been implemented, the ethical elevator will remain stuck on the first floor!

For several years, the leading teams of social scientists exploring the effects of disclosure of conflicts of interest have expressed concern that disclosure "can often forestall more substantial institutional change."[126] George Loewenstein, Daylian Cain, and Sunita Sah have continued to worry that a serious pitfall of disclosure is moral licensing: "the rationalization that, with disclosure, the profession has dispensed with its obligation to deal with conflicts of interest."[127] For this reason, they also caution: "Care must be taken . . . to ensure that disclosure does not replace more effective measures, such as working harder to eliminate conflicts of interest in the first place."[128] Sah similarly warns that "we must take care that once disclosure is implemented, it will not inoculate against more systemic change."[129] She warns against viewing disclosure as an "all-encompassing solution" and argues that laws and policies that help eliminate conflicts of interest should be "the first priority."[130] Kanter and Loewenstein also express concern that disclosure can "crowd out" more effective solutions.[131] These concerns have been echoed by bioethicists. For example, Tod Chambers alerts readers to "moral misdirection," which occurs when disclosure of conflicts causes people to believe that the ethical issues raised by the disclosed relationship have been resolved.[132]

A number of scholars have argued, in various ways and to various degrees, that we need separation from or the elimination of financial relationships with industry.[133] But policymakers have not yet acted on these appeals. In my view, the disclosure of conflicts of interest should be given a more modest role in the suite of legal and policy responses to corporate influence. In short, disclosure of conflicts of interest, together with a variety of other tools that might promote transparency, can help identify the nature and extent of corporate influence. But we cannot, and should not, rely on disclosure to eliminate that influence. In order to accord disclosure a more modest role, it is helpful to develop a temporal account of corporate influence and policy responses to it.

V. TOWARD A TEMPORAL ACCOUNT OF CORPORATE INFLUENCE AND RESPONSES

[123]Loewenstein et al., *supra* note 73, at 670.

[124]Cora Koch et al., *Transparency of Conflicts of Interest: A Mixed Blessing? The Patient Perspective,* 17 AM. J. BIOETHICS 27, 27 (2017).

[125]Kathleen E. Bachynski & Daniel S. Goldberg, *Time out: NFL Conflicts of Interest with Public Health Efforts to Prevent TBI*, 24 INJ. PREV. 180, 182 (2018).

[126]Cain et al., *supra* note 73, at 20.

[127]Loewenstein et al., *supra* note 73, at 670.

[128]Loewenstein et al., *supra* note 75, at 427.

[129]Sah, *supra* note 77, at 77.

[130]Sah & Feiler, *supra* note 100, at 101.

[131]Kanter & Loewenstein, *supra* note 106, at 402.

[132]*See* Tod Chambers, *The Illusion of Transparency*, 17 AM. J. BIOETHICS 32, 32-33 (2017).

[133]*See, e.g.*, MARKS, *supra* note 1; Bachynski & Goldberg, *supra* note 125; Krimsky, *supra* note 41, at 116; Schafer, *supra* note 21, at 23.

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

In other work, I have developed a framework for recognizing and addressing corporate influence in public health.[134] That framework emphasizes the ways in which corporations weave "webs of influence" with governmental and intergovernmental bodies, the academy, and civil society (including health professional associations and patient advocacy organizations) in order to protect and promote their commercial interests. I have demonstrated how these relationships create subtle reciprocity and influence that serve to frame public health problems and their solutions in ways that are most favorable to corporate sponsors, and that distort both research and policy agendas, as well as the resulting research and policies. In addition to the concept of "webs" of influence,[135] a number of other concepts have emerged in the academic literature that also provide systemic perspectives on corporate influence. They include characterizing corporate strategies as "playbooks,"[136] and analyzing the impact of commercial products or practices as commercial or corporate determinants of health.[137] Some scholars have also focused on the nature and types of corporate power that inform and underpin these strategies of influence.[138]

I hope to add to these frameworks by articulating the importance of a *temporal* account of corporate influence in public health. Fleshing out such a framework in any one area of medicine or public health will require a much more detailed analysis than I am able to provide in this piece. But the purpose of the temporal account I propose is three-fold. First, the account should help scholars and policymakers recognize that the nature and extent of corporate influence in public health has evolved over time. Recognizing that things were not always this way may help address *status quo bias* or, worst still, a belief that the status quo is immutable.[139] Second, a temporal account should provide a framework for rethinking our legal and policy responses to corporate influence in public health—to take stock of where we are and where we might go. This framework can help us reassess what we can and cannot achieve with the current paradigm of conflicts disclosure, and enable us to develop other tools that can eliminate or mitigate corporate influence. Third, a temporal account can make us attentive to the adaptive practices of industry actors, as their strategies of influence will inevitably evolve in response to these tools. This, in turn, will allow lawmakers and policymakers to revisit, reassess, and refine their approaches.

A. TOWARD A TEMPORAL ACCOUNT OF CORPORATE INFLUENCE

For our purposes, it is helpful to broadly categorize corporate influence in public health and the legal and policy responses to such influence in "waves."[140] The

[134]In this paragraph, I summarize some of the key claims in MARKS, *supra* note 1.

[135]*See* FREUDENBERG, *supra* note 3, at 96; MARKS, *supra* note 1; Gornall, *supra* note 3.

[136]MICHAELS, *supra* note 28, at 17; William H. Wiist, *The Corporate Play Book, Health, and Democracy: The Snack Food and Beverage Industry's Tactics in Context*, *in* SICK SOCIETIES: RESPONDING TO THE GLOBAL CHALLENGE OF CHRONIC DISEASE 205 (David Stuckler & Karen Siegel eds., 2011); Brownell & Warner, *supra* note 16, at 259; and *The Disinformation Playbook*, UNION OF CONCERNED SCIENTISTS (Oct. 10, 2017), https://www.ucsusa.org/resources/disinformation-playbook [https://perma.cc/H726-D8HX]. For the use of "playbook" in a narrower sense, *see* SISMONDO, *supra* note 6, at 144.

[137]*See* Kickbusch et al., *supra* note 4.

[138]*See* Joana M. Lima & Sandro Galea, *Corporate Practices and Health: A Framework and Mechanisms*, 14 GLOBALIZATION & HEALTH, no. 21, 2018, at 1-9; Martin McKee & David Stuckler, *Revisiting the Corporate and Commercial Determinants of Health*, 108 AM. J. PUB. HEALTH 1167 (2018).

[139]On status quo bias, *see, e.g.*, DANIEL KAHNEMAN, THINKING FAST AND SLOW 292 (2011).

[140]The "wave" metaphor has a precedent in public health. *See, e.g.*, Peter Hanlon, et al., *Making the Case for a 'Fifth Wave' in Public Health,* 125 PUB. HEALTH 30 (2011). My characterization of corporate

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

first wave of influence might be characterized as "*emergent influence*." In this phase, corporate actors develop and pilot marketing strategies intended to promote their products by influencing not only "end-users" but also a variety of other actors, including health professionals. Here, corporations begin to experiment with strategies designed to exercise not only market power but also political power. Companies recognize that these strategies are necessary to protect and promote their commercial interests. In this wave, there may be limited or no evidence of these strategies in the public domain. For example, the sugar industry's secret efforts half a century ago to shift critical attention from their own products to dietary fat were only exposed in the last five years.[141]

In the second wave, which I call "*expansive influence*," corporations refine their strategies for the exercise of political, as well as market power, and seek to apply them as widely as possible. In this phase, corporations use relationships with other bodies in government, the academy, and civil society in order to recruit new "partners." So, for example, in the United Kingdom, Coca-Cola funded exercise initiatives in collaboration with a few local government bodies, before using those relationships as precedents for expanding the initiative and building similar relationships with a variety of other local governments.[142] It is during this phase that webs of relationships emerge, implicating institutions within government, the academy, and civil society. At this stage, evidence of influence is usually apparent. The full extent of the influence, however, may not be known, even when the existence of many relationships has been made public.

In the third wave, which I call "*exhaustive influence*," corporate strategies have become so widespread that they have exhausted—or, at least, threaten to exhaust—individuals and entities in government, the academy, and civil society that are independent of industry influence. In this phase, corporations and trade associations work aggressively to maintain and expand their webs of influence, and to ensure that legal and policy responses do not undermine their influence. Sometimes, the numbers will speak for themselves. For example, when more than 80% of the largest patient advocacy groups receive industry funding,[143] we have good reason to be concerned that corporate influence among these entities is becoming exhaustive.[144] At other times, the numbers may not speak for themselves (or, worse still, may provide false assurance).[145] For this reason, we also need qualitative assessments to determine whether influence is exhaustive, or threatening to become so. But policymakers should not, of course, wait for the situation to become that dire before taking action to address corporate influence.

---

influence in waves is broad in a number of ways. First, the timeline for each wave may vary according to the industry sector and the entities affected. Second, given that the processes involved tend to be gradual, we should not expect to find clear delineations between the waves. Third, underlying any wave there may be counter-currents—that is, incidents or events that run counter to or are in tension with the prevailing wave.

[141] *See* sources cited *supra* note 14.

[142] *See* MARKS, *supra* note 1, at 89-90.

[143] *See* McCoy et al., *supra* note 31.

[144] We should also be deeply concerned about the influence of these patient advocacy organizations on others, including policymakers. *See* section III *supra* for a discussion of "co-influencers."

[145] For example, corporate influence among clinical practice guideline committees may become exhaustive, even though only a minority of the members on any one committee has a financial conflict of interest. *See, e.g.*, Lisa Cosgrove et al., *Conflicts of Interest Policies and Industry Relationships of Guideline Development Group Members: A Cross-Sectional Study of Clinical Practice Guidelines for Depression*, 24 ACCOUNTABILITY RES. 99 (2017) (expressing concern about financial conflicts of interest when only one member of a committee has a conflict—a concern exacerbated when that member is the committee chair).

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

B. Toward a Temporal Account of Legal and Policy Responses to Corporate Influence

It is also helpful to consider legal and policy responses to corporate influence in analogous waves. In the first wave, "*emergent responses*," the problem of corporate influence is primarily characterized as one of individual financial conflicts of interest, and laws and policies focus on the disclosure of those conflicts. Individuals who are exposed for failing to disclose relationships with the private sector are subject to naming and shaming. But institutional conflicts of interest and systemic perspectives on corporate influence are neglected. Where attention is paid to institutions, the focus is often narrow and *ex post*—pursuing accountability for one bad actor or a small group of bad actors. The first criminal proceedings against Purdue Pharma for the fraudulent marketing of OxyContin, a case that was settled in 2007, might be considered an example of that.[146]

The thousands of cases currently pending against a variety of opioid manufacturers and distributors[147] might be seen as evidence of *expansive responses* to corporate influence. But, as with the proliferation of disclosure policies, the effect of these approaches should not be overestimated. They are certainly responses to influence, but they cannot be relied upon to neutralize that influence. On the contrary, despite the inglorious history of opioid industry practices, government agencies continue to partner with drug companies in efforts to address the opioid epidemic, thereby creating further opportunities for corporate influence.[148] These partnerships are likely to promote highly-profitable pharmaceutical solutions to both pain management and addiction at the expense of other measures that also warrant exploration, among them, increased regulation of pharmaceuticals and drug company marketing practices.[149]

In my view, the goal for policymakers and institutional leadership should be to develop counterstrategies of influence that are as ambitious as the corporate strategies of influence they seek to address. Although it may never be possible to achieve this entirely, the aspiration should be toward *exhaustive responses*, that is, a comprehensive suite of measures designed to eliminate and/or truly counteract corporate influence in public health. These measures must tackle the cumulative effects of the webs of relationships that corporations employ to exercise influence. This will require systemic and structural solutions to corporate influence—including "sequestration" or separation—as well as other reforms to keep corporate actors at arm's length.

The efficacy of these interventions should be periodically reassessed and appropriate adjustments made in order to address the adaptive practices of industry actors. Disclosure and other measures to promote transparency can facilitate such assessment by both researchers and policymakers. Attempts to measure corporate influence, the effects of corporate influence, and the efficacy of interventions designed to address corporate influence will be difficult.[150] So we should not wait for conclusive evidence before developing strategies to address corporate influence in public health. On the contrary, delaying interventions to tackle corporate influence pending further evidence would play into what some might characterize as a "playbook" strategy of

[146] I discuss this further in Marks, *Lessons from Corporate Influence*, *supra* note 40.
[147] *See id.*
[148] *Id.*
[149] *Id.*
[150] *See, e.g.*, Lima & Galea, *supra* note 138, at 1-3.

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press

corporate influence. We know enough about the pervasiveness of corporate influence in public health and the associated biases to take action now. That said, additional evidence regarding both the efficacy of legal and policy responses to corporate influence and the adaptive practices of industry actors in the wake of those responses can and should be used by lawmakers and policymakers in order to refine their approaches.

CONCLUSION

The earliest proponents of disclosure were aware of its limitations. In 1913, when Louis Brandeis famously wrote that "[s]unlight is said to be the best of disinfectants," he was not arguing *only* for transparency.[151] While calling for disclosure of bankers' commissions or profits, he also contended that the banks' "sources of . . . undue power must be effectually stopped,"[152] and that some bankers' services should be entirely dispensed with. Brandeis, who acknowledged the sunlight metaphor was not his own, borrowed it from *American Commonwealth* (1888).[153] In that book, Viscount Bryce claimed that, when a "rankling sore in the body politic" is disclosed, it is "half destroyed."[154] But that which is half destroyed may, of course, still fester or endure. Alas, the nuances of the claims by Brandeis and Bryce have been lost through careless repetition.

Lawmakers, policymakers, and institutional leaders in the academy and civil society need to develop counterstrategies that are as ambitious and pervasive as the corporate strategies of influence they seek to address. Disclosure alone cannot perform that function. By increasing transparency, policymakers may *illuminate* corporate influence but they cannot and should not rely on transparency to *eliminate* corporate influence. It is time for a new wave in public health law and policy that recognizes the limitations of disclosure of conflicts of interest; accords it a more modest role; and explores new approaches, including separation and other structural reforms to more effectively address the systemic problem of corporate influence.

---

[151] *See* Louis D. Brandeis, *What Publicity Can Do,* HARPER'S WKLY, Dec. 20, 1913, at 10.

[152] *Id.* at 11.

[153] *See* JAMES BRYCE, THE AMERICAN COMMONWEALTH: TWO VOLUMES 1012 (Liberty Fund Inc. 1995).

[154] *Id.*

https://doi.org/10.1177/0098858820933499 Published online by Cambridge University Press