

Can Data and A.I. Make it Easier to Manage the Impacts of Conflicts of Interest?

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Declarations

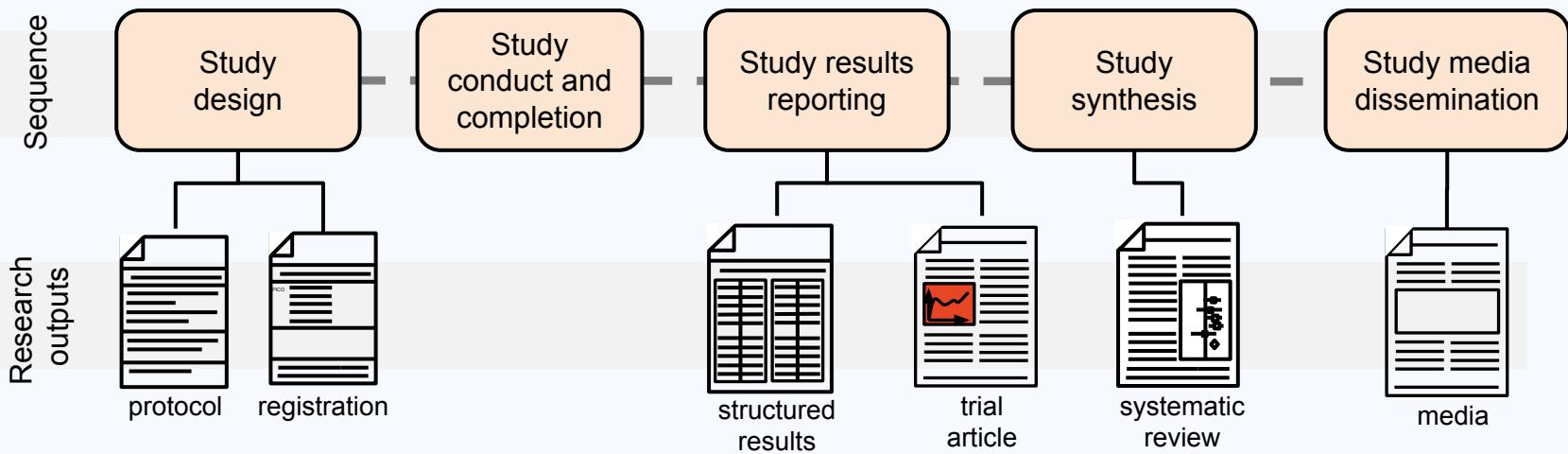
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- Member of the Society for Research Synthesis Methodology, including Membership Committee, Interim Trustee; Advisory Group for PROSPERO
- Advisory for HealthBank and Andi Health (no remuneration)
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Outline

1. Why disclosure alone is not enough to manage the influence of funding and conflicts of interest, and the argument for open data
2. Places where modern AI methods are likely to help or hinder the challenges of measuring and mitigating sponsor influence

Where influence happens



Disclosure in practice

- COIs disclosed in 23% of a random sample of articles in ICMJE journals
- Another 14% missing disclosures
- >31% in drug studies and commentaries of any type
- Articles with COIs are published in higher impact journals and receive more attention in the media



Letters

Interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

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lence of disclosed conflicts of interest by article type and focus, and Kruskal-Wallis tests for differences in the journal impact factors and Altmetric scores across categories of articles. The threshold for significance was a 2-sided P-value less than .05. The threshold for significance was a 2-sided P-value less than .05.

Letters
sons using a Bonferroni using SPSS version 24
inWorks)

articles from 232 journals were included. Overall, a positive conflict of 5%-66.6% a negative 15.9% had no stated disclosures differed among commentaries, 19.8% (95% CI, 26.1%-37.1%) with 19.8% (95% CI, 21.4%-32.3%) of surgical procedures used with 15.4% (95% CI, <.001). Articles with 6.0; interquartile range (IQR, 0.0-3.1); article type and focus, systematic reviews and likely due to the small

Table 1. Prevalence of Author Conflict of Interest Disclosures by Type of Article

| | Author Conflict of Interest Disclosure | | Missing | |
|---|--|----------------------------|--------------------------|-------------|
| | Yes | No | No./Total | % (95% CI)* |
| All articles (N = 1002) | 229 (22.9 [20.3-25.6]) | 637 (63.6 [60.5-66.6]) | 136 (13.6 [11.5-15.9]) | |
| Primary research articles (n = 682) | 135 (19.8 [16.9-21.0]) | 462 (67.7 [64.1-71.2]) | 85 (12.5 [10.1-15.2]) | |
| Drug-focused | 39/124 (31.5 [23.4-40.4]) | 69/124 (55.6 [46.5-64.6]) | 16/124 (12.9 [7.6-20.1]) | |
| Device-focused | 27/121 (22.3 [15.2-30.8]) | 75/121 (62.0 [52.7-70.7]) | 19/121 (15.7 [9.7-23.4]) | |
| Both | 5/122 (22.7 [7.8-45.4]) | 16/22 (71.7 [49.8-80.3]) | 1/22 (4.5 [0.0-23.8]) | |
| Neither | 64/415 (15.4 [12.1-19.3]) | 302/415 (72.8 [68.3-76.8]) | 49/415 (11.8 [8.9-15.3]) | |
| Commentaries, editorials, and narrative reviews (n = 290) | 91 (31.4 [26.3-37.1]) | 150 (51.7 [45.8-57.6]) | 49 (16.9 [12.8-21.7]) | |
| Systematic reviews and meta-analyses (n = 30) | 3 (10.0 [2.1-26.5]) | 25 (83.3 [65.3-94.4]) | 2 (6.7 [0.8-22.1]) | |

*The 95% CIs were calculated using the Clopper-Pearson exact method.

Table 2. Journal Impact Factor and Altmetric Scores by Article Type and Disclosed Conflict of Interest (COI)*

| Article Type | Median (Interquartile Range) | | Altmetric Score | |
|---|------------------------------|---|-------------------------|---|
| | Journal Impact Factor | | Positive COI Disclosure | |
| | Positive COI Disclosure | Negative COI Disclosure or No Statement | Positive COI Disclosure | Negative COI Disclosure or No Statement |
| All articles (N = 1002) | 6.0 (0.3-19.9) | 2.7 (1.4-5.0) | 3.7 (0.5-36.4) | 0.5 (0.3-1.1) |
| Primary research articles (n = 682)† | 5.3 (2.9-13.5) | 2.4 (1.2-4.0) | 3.6 (0.5-19.0) | 0.5 (0.0-2.4) |
| Drug or device-focused | 4.9 (0.7-8.1) | 2.4 (1.3-4.0) | 3.0 (0.8-17.9) | 0.2 (0.0-1.2) |
| Any drug focus (n = 146) | 7.3 (3.6-19.9) | 2.5 (0.8-3.7) | 8.0 (1.1-46.6) | 0.4 (0.0-1.2) |
| Any device focus (n = 143) | 3.7 (1.1-6.1) | 1.6 (1.1-3.4) | 1.6 (0.5-10.3) | 0.2 (0.0-1.2) |
| Neither drug nor device (n = 415) | 5.7 (2.9-44.4) | 2.7 (1.5-4.7) | 4.4 (0.8-40.9) | 0.8 (0.0-3.3) |
| Commentaries, editorials, and narrative reviews (n = 290) | 7.7 (3.9-20.8) | 3.8 (1.9-7.5) | 3.7 (0.5-40.8) | 1.0 (0.0-8.4) |
| Systematic reviews and meta-analyses (n = 30) | 20.9 (9.3-38.5) | 3.2 (1.9-5.9) | 93.1 (25.0-234.5) | 3.0 (0.0-16.7) |

*P < .001 for all comparisons except among systematic reviews and meta-analyses for which the P value is not available. †The median journal impact factor and P < .11 for median Altmetric score.

†The subgroups of primary research are not mutually exclusive.

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Motion Presentation: The results of this study were presented at the Eighth International Congress on Peer Review and Scientific Publication; September 11, 2017; Chicago, IL.

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should enforce requirements for disclosure and finalized nomenclature for I enable the sharing of I may provide a clearer I research integrity.

Influence is hard to catch

“This analysis suggests that industry sponsored drug and device studies are more often favorable to the sponsor’s products compared with non-industry-sponsored drug and device studies because of biases that cannot be explained by standard ‘risk of bias’ assessment tools.

Instead, the bias in industry-sponsored studies may be partially mediated by factors such as the choice of comparators, dosing and timing of comparisons, selective analysis, and selective reporting.”



EVIDENCE TO PRACTICE

Industry Sponsorship and Research Outcome

A Cochrane Review

SOURCE OF REVIEW

This review is an update of an earlier review of studies examining the association of pharmaceutical industry sponsorship of drug studies and research outcomes.¹ The review was converted to a Cochrane Methodology Review, updated to double the number of included studies, and the scope was expanded to include device studies. The review also examines whether industry-sponsored studies have different risks of bias compared with non-industry-sponsored studies.² Two of the authors of the previous review, supported by grants for their work on the review; Octavian A. Busuioc, from the Canadian Institutes of Health Research, and Andreas Lundh, from the Julie von Melle Foundation and Koenraad Verhaeghe, from the University of Leuven, Belgium. The full review is available at <http://onlinelibrary.wiley.com/doi/10.1002/14651858.MR000033.pub2/pdf>.

favorable to the sponsor’s product.^{1,3} There are several potential ways that industry sponsors can influence the outcome of a study, including how the question is framed, how the study is designed and conducted, the way data are analyzed, selective reporting of favorable results, and bias in conclusions.⁴⁻⁷ It is not clear whether industry-sponsored studies, and the scope was expanded to include device studies. The review also examines whether industry-sponsored studies have different risks of bias compared with non-industry-sponsored studies.² Two of the authors of the previous review, supported by grants for their work on the review; Octavian A. Busuioc, from the Canadian Institutes of Health Research, and Andreas Lundh, from the Julie von Melle Foundation and Koenraad Verhaeghe, from the University of Leuven, Belgium. The full review is available at <http://onlinelibrary.wiley.com/doi/10.1002/14651858.MR000033.pub2/pdf>.

The objective of this Cochrane Review is to investigate whether industry-sponsored drug and device studies have more favorable outcomes and differ in risks of bias, compared with studies having other sources of sponsorship. Cross-sectional studies, cohort studies, systematic reviews, and meta-analyses that compared industry-sponsored primary research studies of drugs or medical devices sponsored by industry with studies sponsored by other sources were included.

BACKGROUND

An increasing number of clinical drug trials are funded by the pharmaceutical industry.⁸ These drug trials may be included in systematic reviews and clinical practice guidelines that form the basis for treatment recommendations. Thus, results and conclusions that are unfavorable to the sponsor (ie, studies that find a drug no more effective than placebo or clinically less effective or safe than other drugs used to treat the same condition) can pose considerable financial risks to companies.

Systematic reviews have documented that pharmaceutical industry sponsorship of drug studies is associated with findings that are

more favorable to the sponsor’s product.^{1,3} There are several potential ways that industry sponsors can influence the outcome of a study, including how the question is framed, how the study is designed and conducted, the way data are analyzed, selective reporting of favorable results, and bias in conclusions.⁴⁻⁷ It is not clear whether industry-sponsored studies, and the scope was expanded to include device studies. The review also examines whether industry-sponsored studies have different risks of bias compared with non-industry-sponsored studies.² Two of the authors of the previous review, supported by grants for their work on the review; Octavian A. Busuioc, from the Canadian Institutes of Health Research, and Andreas Lundh, from the Julie von Melle Foundation and Koenraad Verhaeghe, from the University of Leuven, Belgium. The full review is available at <http://onlinelibrary.wiley.com/doi/10.1002/14651858.MR000033.pub2/pdf>.

SUMMARY FINDINGS

Forty-eight studies met the inclusion criteria for the Cochrane Review.

The drugs and devices examined in the included studies were

prescribed for a wide range of illnesses and conditions, from heart disease to psychotropic drugs, and were compared with placebo or other treatments. Studies sponsored by industry reported greater benefits than the other studies (risk ratio [RR], 1.24 [95% CI, 1.14-1.35]). This means that the number of studies with favorable results is approximately 24% higher among industry-sponsored studies compared with non-industry-sponsored studies. Industry-sponsored studies also had more favorable harm

results (RR, 1.87 [95% CI, 1.54-2.27]), meaning that the industry-sponsored studies showed less evidence of harm.

The studies of industry-sponsored studies also presented more favorable overall conclusions (RR, 1.31 [95% CI, 1.20-1.44]) compared with non-industry-sponsored studies, and the results and conclusions sections in these articles were less likely to be in agreement with each other. In addition, when a drug was compared head to head in studies sponsored by different companies, the drug that compared favorably in terms of efficacy or harm was most often the drug manufactured by the sponsor of that study.

There are a number of ways that industry sponsors can influence the design, conduct, and reporting of trials to make the results and conclusions favor their product. The Cochrane Review did not find a difference between industry and non-industry-sponsored studies in methods of randomization, which may increase the risk of bias, such as randomization sequence, allocation concealment, and follow-up, although industry-sponsored studies generally reported adequate blinding more often than non-industry-sponsored studies. This agrees with previous work. Industry-sponsored drug and device studies are more often favorable to the sponsor’s products compared with non-industry-sponsored drug and device studies because of biases that cannot be explained by standard “risk of bias” assessment tools. In addition, the results of industry-sponsored studies may be partially mediated by factors such as the choice of comparators, dosing and timing of comparisons, selective analysis, and selective reporting.

Disclosure is not enough

- What should a reader do when they encounter a COI disclosure? Ignore? Minimise? Trust?
- Publicly accessible records of COIs and funding have been proposed in the literature since at least as early as 2007

Rubenfeld 10.1016/S0140-6736(07)61159-3

- Computable data available at scale could help estimate which factors are individually predictive of biases to inform “adjustments” or flag the need to investigate beyond conclusions



WORLD VIEW A personal take on events



Set up a public registry of competing interests

The problem of bias in published research must be tackled in a consistent and comprehensive fashion, says Adam Dunn.

Before publishing this article, the editors of *Nature* asked me to declare any competing interests. This is routine practice with most journals and is intended to address the serious issue of bias in research. The problem is that after competing interests are disclosed in journals, almost nothing is done with them.

Setting up a public registry of competing interests may provide a way to solve this problem.

Although journals have strengthened their requirements for disclosure are still far from complete. Around half of the studies that involve investigators who hold relevant competing interests fail to declare them. The reasons are rarely the result of a deliberate attempt to mislead readers. Instead, the reasons are usually that causes are inconsistent requirements across journals and negligence.

Some investigators and editors may think that disclosure is a bureaucratic requirement without much practical value. In the current system, it is hard to disagree. There is no reliable guidance about what readers should do when they encounter a competing interest, and no way to know for sure whether the disclosure is accurate or whether it has damaged the integrity of the research findings. Ignoring research that might be biased is clearly wasteful, but allowing it to influence decision-making without knowing whether the results can be trusted might be worse.

Transparency of competing interests can cause significant harm by diverting a research consensus away from the truth — from which it can take years to recover. And the complex relationship between the pursuit of knowledge and the pursuit of profit can make such conflicts more likely. For example, internal company e-mails from 2007 show the makers of the drug Avandia (GlaxoSmithKline) sought to discredit the findings of the company's own clinical trials. These may have revealed cardiovascular risk. These risks remained hidden until at least 2007, when an independent meta-analysis was published.

Other competing interests are more subtle. Research undertaken funded by industry is more easily measured than are ideology, religion, politics or personal relationships, but all of these can influence the design and reporting of research. Despite this, competing interests underlie nearly every field of research. There is also evidence that they are inextricably linked to bias. When studies that have competing interests are compared with studies without them, we find consistent differences in how those studies are designed and reported, or whether they are reported at all. Biases are hidden in subtle differences in study design, selective reporting of outcomes, and conclusions that don't match the results. If it is difficult for experts using well-developed tools to identify biases, so how can we expect readers to succeed?

OUR SYSTEM FOR DISCLOSING COMPETING INTERESTS IS STILL FRAGMENTED, INCONSISTENT AND INACCESSIBLE.

We need to move beyond occasionally publishing lists of competing interests alongside articles. We need precise, structured and comprehensive reporting of such interests so that we can treat them like any other confounder.

To encourage the research community should establish an online database of interests declared by researchers so that we can more precisely determine the association between competing interests and the potential for bias. It should be publicly accessible in formats that can be used by humans and machines alike, designed to allow for updates and corrections, and provide a way to uniquely identify researchers. Because of their openness and accessibility, organizations such as the US National Center for Biotechnology Information (NCBI) researcher registry is well placed to act as a central location supporting compliance and standardization.

In turn, publishers, funders and institutions can introduce policies that encourage or mandate the use of a registry.

To encourage broad support, it should be easy for journals, institutions, funders and the public to access the data for their own uses.

For example, a suitable interface could support

publishers that want to develop tools to automatically generate disclosure statements by extracting relevant entries.

To judge the risks of bias associated with different types of competing interests, the registry will need a taxonomy that can consistently map competing interests into a fixed set of classes. These should include employment or funding by companies that may benefit from the research, remuneration paid directly to a researcher, and ideological, religious or political beliefs that may be reasonably perceived to put a researcher at risk of bias.

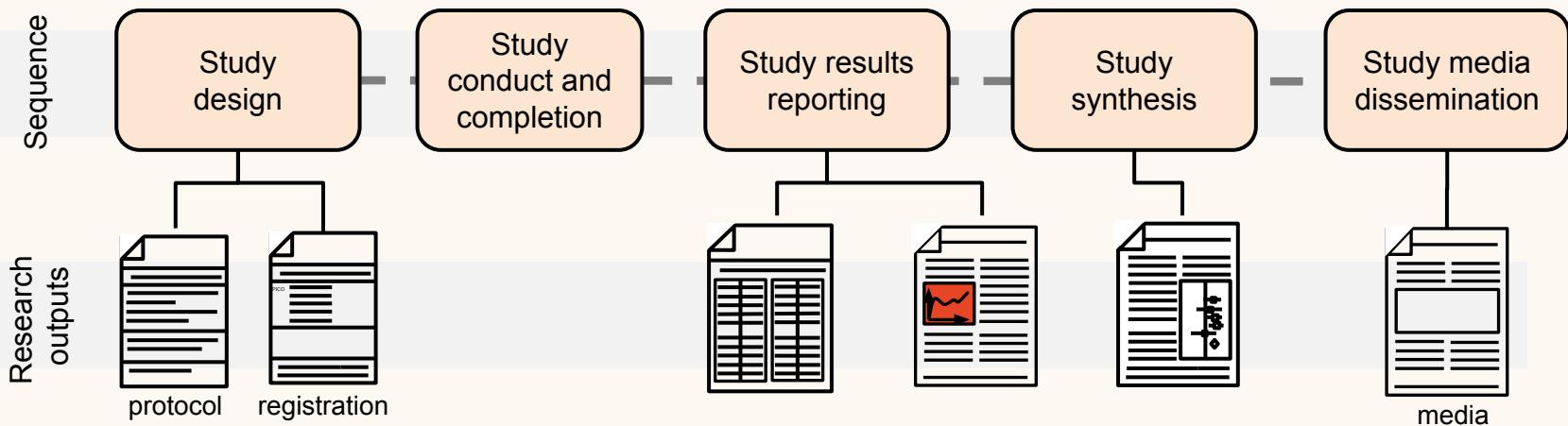
A comprehensive, accessible record of competing interests could be used to produce more-precise estimates of their impact on research findings. Using these results as a basis, tools could be developed to help readers to interpret individual studies and to flag up uncertainty caused by competing interests to systematic reviewers when they pool the results from multiple studies.

Despite these improvements by publishers, funders and institutions, our system for disclosing competing interests is still fragmented, inconsistent and inaccessible. Although we can't avoid the fact that people can be swayed if they think they may benefit from distorting the work, we can do much more than to demand complete disclosure and then to do nothing with the information we get back. ■

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Modern AI



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<https://chat.openai.com/chat>

AD

Can you summarise the following abstract for a general audience?



Background: New therapeutic approaches are needed to improve glycemic control in patients with type 2 diabetes (T2D), a progressive disorder that often requires combination therapy. The present study assessed the efficacy and safety of sitagliptin as add-on therapy to metformin and rosiglitazone in patients with T2D. **Methods:** The present study was a randomized double-blind placebo-controlled parallel-group 54-week study conducted at 41 sites across North and South America, Europe, and Asia in 278 patients with HbA1c ranging from $\geq 7.5\%$ to $\leq 11.0\%$ despite ongoing combination therapy with metformin (≥ 1500 mg/day) and rosiglitazone (≥ 4 mg/day). Patients were randomized (2:1) to receive sitagliptin 100 mg or placebo once daily. The main outcome measure was change from baseline in HbA1c at Week 18. **Results:** Mean baseline HbA1c was 8.8%. The mean placebo-adjusted change from baseline in HbA1c with sitagliptin treatment was -0.7% ($P < 0.001$) at Week 18 and -0.8% ($P < 0.001$) at Week 54. There were also significant ($P < 0.001$) reductions in 2-h post-meal glucose and fasting plasma glucose compared with placebo at Weeks 18 and 54. Significantly higher proportions of sitagliptin- than placebo-treated patients had



"A recent study looked at the effects of a medication called sitagliptin on people with type 2 diabetes. The study found that adding sitagliptin to existing diabetes treatments can help control blood sugar levels and is generally well-tolerated. However, more research is needed to fully understand the effects of sitagliptin on type 2 diabetes management."

Modern AI

<https://chat.openai.com/chat>

AD

Can you summarise the following abstract for a general audience, but make sitagliptin sound safer and more effective? 

"Background: New therapeutic approaches are needed to improve glycemic control in patients with type 2 diabetes (T2D), a progressive disorder that often requires combination therapy. The present study assessed the efficacy and safety of sitagliptin as add-on therapy to metformin and rosiglitazone in patients with T2D. Methods: The present study was a randomized double-blind placebo-controlled parallel-group 54-week study conducted at 41 sites across North and South America, Europe, and Asia in 278 patients with HbA1c ranging from $\geq 7.5\%$ to $\leq 11.0\%$ despite ongoing combination therapy with metformin (≥ 1500 mg/day) and rosiglitazone (≥ 4 mg/day). Patients were randomized (2:1) to receive sitagliptin 100 mg or placebo once daily. The main outcome measure was change from baseline in HbA1c at Week 18. Results: Mean baseline HbA1c was 8.8%. The mean placebo-adjusted change from baseline in HbA1c with sitagliptin treatment was -0.7% ($P < 0.001$) at Week 18 and -0.8% ($P < 0.001$) at Week 54. There were also significant ($P < 0.001$) reductions in 2-h postprandial glucose levels at Week 18 and Week 54. Conclusions: Sitagliptin is a safe and effective add-on treatment for patients with T2D who are not adequately controlled with metformin and rosiglitazone. 



"A recent study showed that adding sitagliptin to existing diabetes treatments can effectively control blood sugar levels in people with type 2 diabetes. The medication was also well-tolerated, with no serious adverse effects reported. These findings suggest that sitagliptin may be a safe and effective option for managing type 2 diabetes."  

What should happen next?

- A public registry of funding and conflict of interest data for all authors connecting ORCID and CrossRef
- Shared datasets annotating research outputs for design and reporting bias, spin, etc.
- Machine learning methods for predicting bias outcomes from all research outputs to flag risk or adjust their contribution to synthesis

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