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Lactation Newsmakers: Protecting Breastfeeding From Conflicts of Interest

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Abstract

In order to maximize profits from sales of breastmilk substitutes, manufacturers use a whole gamut of strategies to interfere with the effective implementation of policies that protect, promote, and support breastfeeding (e.g., the *International Code of Marketing of Breastmilk Substitutes* with its subsequent World Health Assembly resolutions and the *Global Strategy on Infant and Young Child Feeding*). Their strategies create, among other problems, personal and institutional conflicts of interest. Effective Conflict of Interest policies are therefore needed for ensuring that governments, international organizations, non-governmental organizations, and health professionals can protect their independence, integrity, and credibility in order to work in the best interests of children. Conflicts of interest are discussed by Dr Lida Lhotska and Dr Judith Richter, who have been actively involved in these issues internationally. Lida Lhotska holds a BSc in Biology and a PhD in Anthropology. Her international work spans over 25 years. She headed the Infant Feeding and Care team for UNICEF and subsequently joined the IBFAN-Geneva Infant Feeding Association team, always focusing on advancing the protection of breastfeeding through legal and other policy measures. Judith Richter has a multidisciplinary background combining knowledge in the humanities with health sciences (PhD Social Sciences; MA Development Studies; MSc Pharmaceutical Sciences). Her work as a freelance researcher for United Nations agencies, governments, and civil society organizations and networks has centered on safeguarding their capacity to hold transnational corporations accountable. In her interview, Judith Richter explains why conflict of interest regulation matters to health professionals working in the field of lactation.
(MA = Maryse Arendt; LL = Lida Lhotska; JR = Judith Richter)

Keywords

breastfeeding, conflicts of interest, Global Strategy for Infant and Young Child Feeding, International Code of Marketing of Breast milk Substitutes, nutrition policy, politics of breastfeeding

Interview With Lida Lhotska

MA: I have heard you using arguments about conflicts of interest in many policy meetings. How and when did your interest in the theme of Conflict of Interest [CoI] arise?

LL: I became aware of CoI issues while working for UNICEF. At the end of the 1990s the UN [United Nations] Global Compact was announced by the then UN Secretary General Kofi Annan without any prior debate at the UN General Assembly. Suddenly we started hearing more and more about *corporate social responsibility* and *public-private partnerships*. At that time our small team, Helen Armstrong, David Clark, Gabrielle Palmer, Dora Gutierrez, and I were working with WHO on the *Global Strategy on Infant and Young Child Feeding* (GSIYCF; WHO/UNICEF 2003), which aimed to consolidate international infant feeding policies. Baby food manufacturers were trying hard to become part of the process and it was not easy to keep them out. The CoI argument, however imperfectly presented at the time, helped. This pressure made us alert to the need for the GSIYCF to tackle the problem we had envisaged, namely that the baby food industry would interfere with and impede implementation.

Lida Lhotska

Judith Richter

MA: Can you explain a bit more what you mean by "interference?"

LL: Basically, it was important to ensure that the baby food industry should not present itself as a "stakeholder" in infant and young child feeding policy-making and program-development to "help implement the *Strategy*." So, to minimize the risk of such interference, the *Strategy* defined specific roles, obligations, and responsibilities for each concerned actor. Those for the commercial sector are specified in Paragraph 44. It tells companies that they have two roles: first to comply with the *International Code* [*IC*] and subsequent relevant WHA [World Health Assembly] resolutions and, second, to manufacture products according to

Codex Alimentarius standards. Over the years this safeguard has been helpful as long as policy-makers, UN staff, and professionals remember it exists and have not submitted to the culture of "stakeholderisation."

MA: After the GSIYCF was adopted with these obligations and responsibilities your concerns did not go away. . .

LL: Oh, no. They followed me when I moved to Geneva to work for IBFAN-GIFA. It became clear that unless the capacity to understand CoI issues was built at all levels and linked to the Para 44 and the *IC* and subsequent relevant WHA resolutions, implementation of the GSIYCF would be easily compromised. A number of IBFAN colleagues were clear on CoI and on the need for safeguards. After all, they were the ones who successfully introduced CoI provisions into some of the WHA resolutions. However, we did not have a systematic overview and a theoretical basis. So, we asked Judith Richter to put together a document, *Conflicts of Interest and Policy Implementation: Reflections From the Fields of Health and Infant Feeding* (Richter, 2005). From then on, the issue of CoI has been always part of my work.

MA: IBFAN-GIFA has also worked on breastfeeding and human rights. Is there any link between human rights and the CoI issue?

LL: The short answer is "absolutely, YES!" In 1999, Stephen Lewis, former Deputy Director of UNICEF, recast IC violations as violations of human rights. It is good to quote him fully here: "Those who make claims about infant formula that intentionally undermine women's confidence in breastfeeding are not to be regarded as clever entrepreneurs just doing their job, but as human rights violators of the worst sort." As Lewis well understood, the right to information is embedded in human rights' instruments. Only on the basis of full, accurate, and independent information can mothers, fathers, and health professionals make informed decisions about how to feed a baby. Inaccurate, misleading, profit-motivated promotional propaganda about baby food violates that right. So, when companies flout their role defined in the GSIYCF and when our governments, health professional bodies, and individuals, the UN, NGOs etc. allow them to overstep the boundaries, the risk of CoI increases and thus the potential for harm to babies and their mothers (Lhotska et al., 2012).

MA: Could you give the readers a definition of Conflict of Interest?

LL: I will leave it to Judith to elaborate on the definition. I would just like to emphasize one point: If it seems to you [the reader] that something is "fishy," if you perceive that there is perhaps a CoI in some IYCF related policy-making or program development process, activity, or event, raise questions and inquire. People responsible for that process, activity, or event are the ones with a duty to respond to your concerns and, if need be, to take corrective measures.

MA: Lida, how would you explain why health professionals working in the field of lactation should be interested in CoI?

LL: I do not doubt for a second that most, if not all, Lactation Consultants have an absolute clarity regarding their obligations, but there are always those who try to manipulate reputable health professionals to serve their commercial interest. Research shows clearly that health professionals are not immune to commercial strategies. Even those who are aware of a conflict of interest tend to underestimate the extent to which their professional judgment could be biased by a personal financial interest.

How often have I, in discussing Conflicts of Interest, heard: "Me? No, no, no—never! Others perhaps can be influenced, but not me!" In the past, I would have reacted the same way. But then I learned about how insidious CoI are, how the psychology of reciprocity works; how we all have biases and blind spots. Now I know, that NO ONE is immune! We all need the protection of good safeguards, policies that help us and our institutions, associations, and universities to avoid CoI. I have read articles by LCs asserting that "everyone has a conflict of interest" as an excuse not to worry about it. Such statements and attitudes trivialize the risks to their clients and their own professional integrity.

Mothers may not be sufficiently informed or aware to make the best decisions for their babies. These mothers need to be able to trust their LC; they must trust that if a breast pump is suggested and/or rented, that it is the appropriate one for that individual mother and that its selection was not motivated by financial gain for that LC. Therefore, avoiding all CoIs is the aspirational ideal. The International Lactation Consultants Association had a clear principle to "adhere to *the International Code of Marketing of Breastmilk*

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Substitutes and its Subsequent World Health Assembly Resolutions."

MA: Could you explain now the link between the *IC* and CoI?

LL: What the *IC* and resolutions say about CoI is perhaps best explained in the 2nd edition of the *Code Essentials 3: Responsibilities of Health Workers Under the International Code of Marketing of Breastmilk Substitutes and Subsequent World Health Assembly Resolutions* (IBFAN International Code Documentation Center, 2018). It is important that LCs know about the *Code Essentials* 1, 2, 3 and 4 series (IBFAN International Code Documentation Center, 2018). I also recommend an article "Avoiding Conflict of Interest in the Field of Infant and Young Child Feeding: Better Late Than Never" by David Clark (2017), Legal Specialist, Nutrition Section, UNICEF.

So, in summary, the *IC* itself does not use the term CoI but there are WHA resolutions on infant and young child nutrition that specifically address conflicts of interest. They emphasize the need to avoid CoIs in [the] IYCF program, including in medical and health education, and to protect health workers working in infant and young child health from financial or material inducements that create CoI.

The 2016 WHA resolution contains the *Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children* (WHO, 2016; 2017), which applies to all commercially produced foods that are marketed as suitable for infants and young children from the age of 6 –36 months, clarifies what such inducement are. It recommends that health workers, health systems, health professional associations, and nongovernmental organizations avoid situations of conflicts of interest and be prohibited from engaging with manufacturers and distributors in a range of activities. Importantly, the *Guidance* also talks directly to the manufacturers. It calls on them not to create conflicts of interest in health facilities or throughout health systems—but it would be illusionary to believe the companies comply, wouldn't it? Certainly not without monitoring and enforcement systems at national level in place. We have learned that lesson over the past decades.

MA: How could I implement a CoI policy in my working environment?

LL: No solitary person should carry the burden of having to figure it all out for her/himself. As you explained, institutional policies are in place, so the key focus, in my view, should be on reviewing those policies to see whether they indeed take all the CoIs into account, and amend them if necessary. Then, CoI policies should be fully implemented. In this manner, the judgment, independence, and credibility of the profession would be well safeguarded.

MA: How can I make my colleagues aware of the importance of learning about and addressing CoIs?

LL: I have mentioned the *Code Essentials* (IBFAN International Code Documentation Centre, 2018) as one good source. Another one is the annotated slide show by Judith Richter (2016). But when it comes to their working environment, things get confusing. We in IBFAN received questions: "If I take sponsorship from this particular company, for this particular conference, is it OK or not?" "If I go to a meeting where there is a person from a company, will I have a CoI?" I hope that what I tried to explain in this discussion makes it clear that there is no quick fix. People need to engage in honest discussions and work out for themselves, their association, organization and so on, a system that helps them identify and adequately deal with conflicts of interest in their area of work.

Interview of Judith Richter

MA: How and when did your interest in the theme of CoI arise?

JR: As a health professional I have long been interested in CoI, even if I did not use that term at the time. For example, in the [19]70s, when I was Vice President of the Swiss Pharmaceutical Student Association (ASEP), we advocated that pharmacists should refuse shop window decorating by pharmaceutical companies. We felt this would cause the public to see pharmacies as marketing outlets for the companies and diminish the pharmacists' capacity to give independent, non-product-centered, health advice.

In the 1990s, IBFAN-Europe asked me to contribute to discussions on how IBFAN members could best address CoI such as infant food manufacturers and pharmaceutical companies sponsoring health professional associations and continued education. We also discussed the possible CoI through financial relationships of lactation consultants with breast-pump manufacturers. At the time, I was also invited by Health Action International Europe—a network similar to IBFAN, which works on pharmaceutical issue—to explain my concerns related to sponsorship by wealthy venture philanthropists (e.g., Bill Gates). It is known in CoI research circles that the rise to dominance of the neoliberal economic model has increased existing CoI and created new ones.

My work as a sociologist on adequate and effective public interest safeguards, including regulation of conflict of interest, started in 2002. At the time, I had just finished a long-term consultancy for UNICEF on the possibilities for regulation of the infant food

industry in a "globalizing world," which was published as the book *Holding Corporations Accountable* (Richter, 2001). My concern, like that of Finnish researcher, Eeva Ollila (2003), was that so-called global public-private partnerships for health (GHPPP) and multi-stakeholder initiatives (MSIs) risked undermining the capacity of public institutions, health professionals, and health and nutrition advocates to act in the public interest. The Finnish government asked me to investigate which safeguards were in place—or not in place—to prevent this undermining of public health. I found out that the then Director-General of WHO, Dr Brundtland, had assured WHO Member States that WHO would develop staff guidance and training to recognize and avoid CoI.

When I interviewed WHO staff, they informed me that this project had been halted, that there was pressure to regard health related corporations as "partners" rather than as commercial entities and that CoIs were seen as obstacles to "more flexible ways" of working. Lower level staff feared they might not now be able to ward off industry influence. A Senior Legal Officer informed me that the existing CoI definitions had been perceived as "too constraining."

This motivated me to explore existing CoI theories and guidelines. I hoped this would help resolve misunderstandings, which may have stood in the way of developing CoI guidance on WHO relations not only with companies but also venture philanthropies, since both are guided by business logic (Richter, 2004).

A little later IBFAN-Geneva Infant Feeding Association asked me to explain Paragraph 35 of the *Global Strategy on Infant and Young Child Feeding*, which stated, "all partners should work together"—also by forming alliances and partnerships—"consistent with accepted principles for avoiding conflicts of interest." Nowhere, however, were these principles spelled out. I explored ways of addressing this gap in the publication *Conflicts of Interest and Policy Implementation* (Richter, 2005).

MA: Could you give the readers a definition of CoI?

JR: In that publication I referred primarily to three definitions, one developed for public service in the countries of the Organisation for Economic Cooperation and Development (OECD, 2003), and two from the area of health. The first definition I quoted was developed by the political philosopher, Professor Dennis F. Thompson.

> A conflict of interest is a set of conditions in which professional judgement or actions concerning a primary interest (such as a patient's welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain). (Thompson, 1993, p. 573)

I found this definition useful to explain to health practitioners why one talks about conflicts of "interest". This definition, with minor revisions, has since been spread widely through the US Institute of Medicine report on *Conflicts of Interest in Medical Research, Education and Practice* (Lo et al., 2009, p. 5). The other definition I highlighted at the time was articulated by Conflict of Interest expert and Law Professor, Marc Rodwin (1993). Today he writes:

> A conflict of interest exists where an individual has an obligation to serve a party or perform a role and the individual has either: 1) incentives or 2) conflicting loyalties, which encourage the individual to act in ways that breach his or her obligations. (Rodwin 2017, p. 10)

Rodwin (2017) follows the way the term has been used in American law for most of the 20th century. As I followed his work, I found his summaries of legal definitions of great help in understanding the very nature of CoI. The legal definition is complex, true. The US Institute of Medicine's (IOM) report (Lo et al., 2009) has promoted its Thompson-IOM definition as the "most workable" one, as David Clark (2017) noted in his article.

I would like to use this opportunity to, once more, advocate basing CoI policies on a traditional legal definition, for two reasons: first, because it highlights obligations/duties as key reference points. In a recent paper, Professor Rodwin (2017) called attention to the fact that the hands-on, more simplistic, Thompson-IOM definition differs from legal definitions. He was particularly concerned about the description of CoIs as a conflict between a "primary interest" and a "secondary interest," rather than as "conflicts between *obligations* and interests" (Rodwin, 2017, p. 4). Indeed, obligations are on a wholly different plane to "secondary" financial interests.

Applying Rodwin's legal definition requires individuals to articulate what their legal and key ethical duties are. We need to know those duties to assess whether an individual has financial ties or divided loyalties that conflict with those duties. It reminds us of basic ethical principles of health professionals from the age-old dictum "First, do no harm" and the duty to give unbiased, clear, information and advice.

Had this been more widely understood, it would also have helped to avoid the current chaos in the nutrition world created by proposals that CoI policies could have as a reference point the "joint endeavor" of public-private hybrids such as the Scaling-Up Nutrition (SUN) initiative (Richter 2015).

MA: So, this reflects the need to spell out key legal and ethical duties for individual health professionals or lactation consultants. So how would it apply to people working in the international health arena?

JR: I only gave you a first example of widely accepted guiding ethical principles for health professionals.

Health professionals and lactation consultants should also be aware that other obligations derive from the constitutions of the UN and WHO and human rights' documents. They do not only apply to public health experts.

For example, the *United Nations Convention on the Rights of the Child* (UNICEF, 1989/90) calls on all societal actors to always act "in the best interest of the child." It also enshrines the "right of the child to the enjoyment of the highest attainable standard of health" and the obligation to "ensure that all segments of society, in particular parents. . . are informed. . . and supported in the use of basic knowledge of child health and nutrition, [and] the advantages of breastfeeding" (UNICEF, 1989, Art. 24.1 and 24.2[e]). And, if the ILCA has indeed adopted a principle to adhere to the *IC* and subsequent WHA resolutions, then this would encompass the duty to protect breastfeeding—not only to support and promote it.

MA: Are there other reasons to prefer a legal definition?

JR: My second reason for preferring a more complex legal definition is that it corresponds with recent research in global governance in which law professor Anne Peters (2012) recommended including the issue of conflicting loyalties in CoI conceptualizations. As Rodwin (2017) points out in his recent work, the Thompson-IOM definition may lead to overlooking the crucial issue of split loyalty. Financial CoI are created by all kind of incentives. They are relatively easy to understand. Research from many professional fields has shown that financial incentives may induce us, knowingly or unwittingly, to act in a way that may violate our *obligations* towards the persons we are meant to serve. Conflict of Interest conceptions, which include loyalty issues, are more difficult to explain. They spell out how, for example, how health professionals may have split their loyalty to the person they are meant to serve because they have conflicting roles.

A widely quoted example is the conflict of roles when physicians act as researchers on a new drug while caring for the sick research participant. In the public health arena health professionals or public health officials often take on conflicting roles of fundraising while, at the same time, elaborating institutional fundraising rules and policies. How much bad policy advice has resulted from this situation?

One can argue that, over the past 20 years or so, many UN personnel have been pushed into a position of split loyalty. The model underlying global PPPs—or "multi-stakeholder partnerships" or—"platform" asks them to engage in a "spirit of trust" and to ensure "win-win situations" for both parties. The understanding that the duty of public officials and health professionals is to ensure that interactions with commercial actors are fully in the interest of those they are meant to serve got gradually eroded. Also lost is the notion of arms-length distance between public interest and commercial actors, the recognition that such interactions require vigilance, not blind trust, and that, ultimately, corporate employees must manage public-private interactions for the maximum advantage of their employers—as those who have studied the so-called corporate social responsibility initiatives know. This sounds far removed from the world of lactation consultants, but it is not, since this partnership approach is being spread via international initiatives such as the *Scaling Up Nutrition* (SUN) "movement."

MA: This all sounds rather complicated. Is there a simpler way to bring the message home?

JR: Yes. Since IBFAN-Geneva Infant Feeding Association (GIFA) first asked me to explain the matter, I started to collect popular, common sense sayings such as s/he "who pays the piper, calls the tune" or "you do not bite the hand that feeds you." More recently, I presented simple images in IBFAN-GIFA (2018) press conference on conflicts of interest in global health governance, which you can view on the internet where you can also find the full PowerPoint presentations of all three presenters.

In Germany, we say: "*kleine Geschenke erhalten die Freundschaft*" (small gifts maintain the friendship), showing popular awareness that a sense of obligation can come from even small financial contributions. Research shows that we commonly underestimate the extent to which even small gifts influence our judgement. Companies build on what conflict of interest theory calls the "bias blind spot," the blindness to which Lida referred. I encourage the readers of this journal to look at the contribution of Professor David Klemperer (2018) at that press conference. He quotes pharmaceutical company training material in which the pharmaceutical representatives are taught to build up a feeling of friendship in physicians by inviting them to meals—while never forgetting that they themselves are in a commercial relationship. Look also at the press-conference pictures of a person with a split in the head. It illustrates a point made by Professor Anne Peters (2012), namely that ultimately the conflict of interest rests in our minds—it is a conflict WITHIN us, not between us and commercial actors. Conflicts BETWEEN actors, she writes, are often referred to as conflicting interests.

This picture also makes us understand that people from outside cannot see what happens in our brains,

whether and to what degree we will be influenced by financial incentives or split loyalty issues. And this is why conflict of interest policies try to identify and maximally prevent conflicts of interest before harm is caused.

MA: Could you explain why health professionals working in the field of lactation should be interested in CoI?

JR: Because maximum avoidance of CoIs is a cornerstone of professional integrity and good practice. I would encourage LCs to look at the issues, which have come up in the Conflict of Interest discussions, theory, and law building in other fields, in particular in the relationship between health professionals and pharmaceutical companies. For example, research has shown that physicians who have financial relationships with pharmaceutical companies tend to do two things: prescribe preferentially the medicine of the sponsoring company, even if it is not the best one for a particular ailment; overprescribe, that means they tend to prescribe more medicines than people need.

Such parallels may help LC to argue for full implementation of both the *IC* and BFHI. It protects mothers and babies from relationships that often end up in the displacement of breastfeeding by artificial feeding. I do not know whether your professional associations and networks have addressed the question whether certain financial relationships with breast pump manufacturers can lead to non-essential use of breast pumps and the blurring of the difference between breastfeeding and human milk feeding. At an IBFAN-Regional Meeting a health professional from Macedonia observed that pumps were often promoted in a way to persuade women to view them primarily as a means to more freedom to move around. She felt this could lead to displacement of breastfeeding and a weakening of efforts to create the conditions for women to breastfeed.

MA: How can I make my colleagues aware of the importance of learning about and addressing CoIs?

JR: Just remind them that CoI policies are indispensable tools to protect the capacity of lactation consultants to work for the best interest of babies and their mothers. I hope some of the arguments from our interviews can help you in this task. If you got together to make a list of all the issues you perceive as conflicts of interest that may help sorting out what issues still need to be addressed.

Conflict of Interest theory, moreover, requests under the keyword "perceived" conflict of interests, that whatever situation health professionals or the concerned public perceive as conflict of interest, must be investigated and related issues resolved. This is why the OECD (2003) *Guidelines on Conflict of Interest in Public Service* require that public institutions are open to public scrutiny. Otherwise, they warn, public trust will be lost.

Many health professionals and public servants today point out that it is difficult for them to avoid Conflict of Interest situations since their institution is in a relationship with commercial actors, which put them into this situation. Some theorists deal with this problem under the term of Institutional Conflict of Interest, others under the broader framework of institutional corruption or erosion (Marks, 2019). I cannot go into further discussions on this matter. Suffice to say that it seems unfair to expect individuals to avoid Conflicts of Interests as long as the root causes of their exponential increase are not addressed. Unless political issues are addressed, efforts towards effective Conflict of Interest regulation in the health arena will be undermined (Lhotska & Gupta, 2016; Richter, 2017).

MA: Many thanks Lida and Judith for this very interesting food for thought!

Author's Note

The authors would like to dedicate this interview to Helen Armstrong, a marvelous friend, colleague and mentor, who passed in November 2019. Her integrity, vast knowledge and clarity of thinking have guided us many times through the intricacies of infant feeding. Helen will be sorely missed.

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