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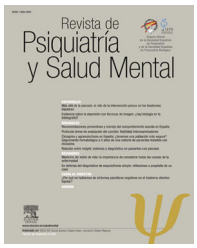

EDITORIAL

Conflict of interest in Psychiatry

Conflicto de intereses en psiquiatría

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A conflict of interest (COI) occurs when non-physician clinicians/physicians feel conditioned by a secondary interest with respect to their primary duties. This conditioning might lead to conduct that is not guided solely by the search for the best possible medical practice. Such inconsistencies have currently given rise to a serious crisis of credibility and lack of confidence in all fields of medicine, which also extends to psychiatry.

The relationships between the pharmaceutical industries with clinicians have been the subject of a considerable amount of literature in which, essentially, indications are given on the (economic) COIs that may affect the decisions that clinicians, researchers and teaching staff take. Under these circumstances, the interests of patients, their families and mental health professionals, and those of the medical industry can differ.

At the same time, the spotlight has focused on the existence of other incompatible situations that had been going unnoticed because of their limited empirical evidence: the so-called non-financial COIs. These inconsistencies stem from the «affective/psychological strain» that certain clinical practices and/or decisions perhaps involve. It has been shown that the proximity of a professional to a specific line of thought or to a political commitment may influence and condition the results of particular comparative studies. This clashes with the primary interest (duty) represented by the wellbeing of individuals with some type of pathology, by scientific advances and by improvements in training.

Conflicting non-financial and financial interests are widespread, both in clinical practice and in psychiatric research and teaching. These contexts are easy to eliminate; however, they have to be identified and handled with greater discernment and efficacy than what is currently happening. It is only in this way that psychiatry will stop being in the spotlight constantly. Resolving these conflicting situations requires a radical change in current coping strategies, which can be considered inadequate and limited in number. Dealing with COIs correctly may mean great long-term advantages for patients, clinicians, researchers and the health care industry itself.

Definition of conflicts of interest

A COI is a situation in which an individual's decision-making (as concerns that person's primary interest) is unduly influenced by a secondary interest, generally of a personal or economic nature. That is, a conflict of interest arises when, instead of complying with ethical standards, individuals make decisions based on their own criteria or act in their own interests or in those of a third party. Such

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situations often appear throughout the work life of professionals, executives and employees, as well as in companies and organisations.

In the last few years, a threat to public health has been created by the fact that patients and society in general lack confidence in the medical profession, constantly questioning its credibility. This scepticism has particularly been focused on psychiatry, even though its circumstances should not be considered to be different from those of other areas of medicine.[1]

These conflicting situations develop from the diversity and the complex demands of current social life. As Lolas Stepke[2] points out, COIs have always existed, but they have now become wider and more universal in nature.

In the field of psychiatry, COIs are produced when clinicians/physicians feel unduly conditioned by a secondary interest with respect to their primary duties, with which they have a professional commitment.[3] These primary duties are patient wellbeing (in the case of clinical professionals), progress and scientific advancement (in the case of researchers), and progress in the education of students and residents (in the case of teaching staff). Secondary interests that may affect the actions of professionals include, among other possible benefits, economic profit for the professionals themselves or for an institution; personal recognition and professional advancement or visibility in the media; granting a relative, friend or colleague a favour; loyalty to a school of thought; and political commitment.[4]

Many COIs are currently evident in psychiatry. Professional codes of ethics usually distinguish between the obligations that members of the profession have and those related to the individuals requiring their services. The possibility that pharmacological research is unduly influenced by the pharmaceutical industry, which drives and funds the research, has become a truism in medical literature, especially in the field of psychiatry.

In the last few years, the relationships between healthcare industries and clinicians have consequently been the subject of numerous articles, basically revealing the COIs that can affect many of the decisions that clinicians, researchers and teaching staff make. Obviously, this situation occurs in all medical disciplines. However, it presents certain differential characteristics in psychiatry, which is a speciality prone to what has come to be called the «medicalisation» of life. This way of thinking essentially consists of making circumstances and adversities in life that could be faced in another manner the object of medical diagnosis and treatment.[1,2,4]

It is therefore especially necessary to bring about a deep, radical change in the culture and the relationships with the commercial sector; such a shift has to begin, first of all, with clarifying COIs, especially those of an economic nature.[5]

Conflict of interests in medicine and in psychiatry

Economic conflicts of interest

A specific type of circumstances that threaten medicine has monopolised the attention of the both the scientific press and the non-specialised press: economic or financial COIs. These conflicts often arise in the relationship between physicians and pharmaceutical companies or other healthcare technology businesses. There is extensive literature describing the different, sometimes subtle, ways by which the relationships that physicians or psychiatrists have with the industry can influence them in their research activities or when it comes to suggesting certain clinical practices.[3,6]

In a thorough review of these situations, Fava describes the main sources of conflict that develop when clinician or researcher falls within any of the following categories: being an employee, shareholder or member of the board of directors of a company; being an occasional or regular consultant, or an occasional or official speaker, for a company; obtaining some type of reimbursement or receiving fees from a company; being a clinical researcher on a clinical trial sponsored by a private firm; and, finally, having a patent.[1]

These types of conflicting contexts happen very frequently, so this area has received a lot of attention, generating notable empirical evidence.[3] It has been shown that accepting funds for trips and lodging for sponsored symposiums or congresses is linked to an increase in prescribing the sponsor's medications; and it has also been shown that, if clinicians have accepted some type of compensation from the pharmaceutical companies selling specific drugs, they are more likely to request the addition of pharmacotherapeutic guidelines for or access to prescribing the drugs in question.[7] For example, strong international interest has been provoked by the case of Dr Josep Baselga, an eminent scientist in the field of oncology and the medical director of the prestigious Memorial Sloan Kettering centre in New York, who did not reveal the more than three million dollars that he had received from the pharmacists with whom he worked.[8]

It has also been demonstrated that studies sponsored by a specific company are much more likely to obtain favourable results for the sponsor's product.[9,10] In a systematic review, Maj concluded that, in 90% of the comparative studies and trials on the efficacy of second-generation antipsychotics, the results favoured the substance belonging to the sponsor of the study.[3,9]

Another potential conflict emerges when scientific societies obtain funding from a specific entity, whether private (the pharmaceutical industry or healthcare technology companies) or public (such as universities, public administrations or research institutions). And the fact is that not just individual motivations exist; collective interests are usually less tangible, but are not less important. Many scientific societies, such as the American Psychiatric Association, get a large part of their income through industry advertising in the form of congress registrations, journal adverts and subsidies for publication.[2] The entities involved can thus exert a certain influence on medical journals and, consequently, on their editorial policies and on the selection of determined articles.

Economic COIs also appear when psychiatric experts and professionals are chosen to contribute to preparing clinical guidelines. An elevated proportion of the experts involved have been shown to have economic or contractual

relationships with public organisations or with pharmaceutical companies whose products are considered (and recommended) in the regulations in these guidelines. Empirical evidence of this is presented in the study by [Stepke],[2] in which research was conducted on many authors of various clinical practice guidelines on common diseases backed by North American and European scientific societies. It turned out that 87% of the authors had some kind of interaction with the pharmaceutical industry. Specifically, 58% of them had received direct financial support to perform research and 38% had worked as an employee or consultant for a pharmaceutical company. Only 2 clinical practice guidelines, out of the 44 analysed, presented specific statements on the personal financial interactions that existed between the guideline authors and the pharmaceutical industry.[1,11]

Another form of economic COI occurs when the researchers themselves waive the right to possess and independently exploit their own data. There are many studies that focus on analysing these situations: for example, Mello et al.[12] explored and analysed the agreements between pharmaceutical industry sponsors and academic researchers. They found that in 80% of the cases the sponsor owned the data obtained from the studies sponsored.

The scientific literature and even the media often emphasise the strain produced between clinical researchers and the healthcare industry about data analysis and the publications deriving from those analyses. Economic COIs also affect verbal diffusion of knowledge. As an example, it is common for scientific presentations to have been reviewed and approved—or even directly prepared—by a specific pharmaceutical company.

The main situations in which there are economic COIs in medicine have been addressed in this article. We now point out that the tensions caused by the link between private and/or public organisms and psychiatric professionals (whether they are clinicians, teaching staff or researchers) can only be handled with a comprehensive approach. Such a course of action would include steps ranging from establishing support for independent researchers free from significant COIs, up to introducing policies for independent training and diffusion that ensure the best daily clinical practices.

Non-financial conflicts of interest

Spurious economic motivations have captured the attention of (and caused alarm in) present-day society. However, these situations are not the only illegitimate influences that affect research and clinical practice in medicine and in psychiatry. Not all COIs are financial and objectively verifiable. There is another important type of discrepancies between primary duty and secondary motivations. They are less explicit, more tacit, but they are not less important because of that. We now turn to considering in detail these non-financial COIs that have gone relatively unnoticed. And, as [Maj] warns,[3] psychiatry may be especially vulnerable to this type of conflicting situations.

One case of a non-financial conflicting situation that mainly affects research in psychiatry is the possible discrepancy between the secondary interest represented by a researcher's loyalty to a specific school or current of thought or a concrete ideology and the main interest (duty) which would be scientific progress.

The impact of this «loyalty effect» on research, especially in the field of psychological interventions, can lead to bias in the results and in the final publications. The mechanisms through which «researcher loyalty» may work are very similar to those that explain the effect of economic COIs in clinical trial results: there is a tendency to select a less effective intervention to compare with the treatment that is preferred by the sponsor or even by the researcher, or to ignore or hide negative results.[3]

Another clear example of a non-financial COI affecting clinical practice in psychiatry is the potential divergence between the secondary interest represented by a psychiatrist's political or social commitment and the main motivation that would be represented by the well-being of individuals. Narrowing down to the sphere of daily clinical practice, this conflict could occur when a psychiatrist opposes the use of drugs or other therapeutic techniques, which could manifest as an obstinate refusal to get to know them and to use them, rejecting even the clinical therapy guidelines. One consequence of this attitude would be that the drugs are finally used only inappropriately and/or in difficult situations, causing serious detriment to patient well-being. Such an attitude and praxis, as [Maj] again indicates,[3] can reach totally reprehensible levels of obstinacy.

This author clarifies this concept with an example: a psychiatrist with a prior idea of not giving drugs to a patient with severe depression (or a psychiatrist who wants to please a senior consultant or an administrator having this idea) denies the patient pharmacological treatment or hospitalisation. If the patient ends up committing suicide, this is a clear and tragic example of the psychiatrist's secondary COI (his or her ideology or political commitment) influencing the primary interest that the professional should have had present at all times (the patient's wellbeing).[3]

To close out this section on non-financial COIs, it should be mentioned that «special interest groups» (also called «academic oligarchies») have been reported. These groups are formed by opinion makers having important conflicts of interest of an economic, ideological or other nature; these leaders play a powerful role in the field of psychiatry, in both clinical practice and in research or teaching, due to their positions as scientific journal editors, directors of scientific societies or contributors to clinical treatment guidelines. Acquiescing to these groups can help a professional career. These leaders can evaluate research projects or subventions presented to public organisms; given their preferences for a certain ideology or through their economic connections, they can favour articles or projects or promote colleagues sharing their ideology and/or their political beliefs. For example, the members of such «interest groups», by virtue of their position of power, can manage to systematically prevent the

diffusion of data that might compromise their interests or ideology.[1]

Proposals

It is evident that psychiatry, just as other medical specialities, is facing the challenge of resolving the multiple conflicts of interest affecting it. This goal can only be achieved through formulating an ethical context that governs the tapestry of relationships and links in use on a daily basis.

As Jadresic & Correa (2004)[13] indicate, persuasion, interpersonal influences and the way to promote change in others are circumstances with which psychiatry constantly deals. Clinical practice focuses on identifying and understanding patient perceptions, thoughts and affects, with the goal of bringing about therapeutic changes. Surprisingly (and these authors reflect this as well), clinicians usually underestimate the influence that other individuals and/or institutions may have on their decisions.

Concern for the coexistence of opposing interests and their potential distorting influence on clinical practice appears mainly, but not exclusively, in the context of ethics. The goals of all conflict of interest policies are to protect patient priorities and needs, strengthen the integrity of the profession and maintain public confidence in medicine and psychiatry.

One of the principal objectives of the various professional collectives (scientific societies and professional associations, among others) should be to identify the desirable future scenarios and the possible ones. This needs to be done to obtain an overall picture of the new challenges facing medical professionals, researchers and teaching staff, and to open debate and analysis as the initial stages of working towards solutions.[3] The first key step to overcome the current situation is assumed to be becoming aware that COIs exist and that they strongly impact clinical, teaching and research practice. As Fava[1] and Vieta[14] defend, a crucial point and a fundamental tool in dealing with COIs is encouraging and defending critical thinking about clinical issues.[14] The need for this «critical thinking» is emphasised as the only way to overcome being «receptors/passive or disoriented readers» of information. One way to strengthen such critical thinking could be through scientific meetings or publications in which the impact of COIs would be reduced as much as possible. Fava gives the case of the meta-analysis as an example: researchers and clinicians with important COIs would not be suited for writing editorials or participating in these studies because their interrelations could bias the results of these knowledge synthesis tools.[1] In fact, meta-analytic studies are not free from controversy about COIs,[15] and prestigious scientific organisations (such as the Cochrane Collaboration, dedicated to performing independent reviews of healthcare interventions) have seen their credibility seriously questioned in the last few years.[16]

Another key area in approaching COIs is changing sponsored medical training and the responsibility that professional and scientific organisations have.[1] Preventing industry-sponsored medical education is defended to encourage more rational, less biased prescription. Fava also points out that these actions could lead to regenerating intellectual thinking and reforming clinical research.[17] Warner & Gluck[17] gather together a series of guidelines and measures for managing COIs in medicine. First of all, they propose that each institution should have an *Advisory Committee on Conflict of Interests*, in which the different levels of the organisation are represented, to support and advise their members. A function of these committees would be to promote educational programmes encouraging ''ethical education'': recognising current COIs and detecting potential future conflicts. The committees would also provide guidelines so that it would be possible to report confidentially COIs in which other individuals could be involved. In professional skills programmes (for example, for medical students or residents), these committees would also be in charge of teaching individuals how to recognise the different circumstances that might make it easier for COIs to arise, as well as in charge of providing strategies to deal with them. In other words, the committees would also be responsible for promoting critical thinking among individuals in training.

Another key point for dealing with and eliminating conflicting influences consists of the need (and obligation) to reveal in detail the sources of funding that might be impacting the professionals' activity, whether in making clinical decisions, in research, in requesting subventions, in presenting study protocols, in scientific publications, or in other frameworks.[17] The 'conflicts of interest' and 'sources of funding' sections in manuscripts (from both private and public organisations) have emerged as the initial key to facing the contamination currently existing in the scientific literature. Practice suggests that it is best to control up to even the most subtle suspicions by complete transparency. And if there are still any doubts, clarify them, preferably in committees set up expressly for this task.[2] As Dal-Ré[18] comments, professional medical publication associations such as the Committee on Publication Ethics (COPE) and the International Committee of Medical Journal Editors (ICMJE) have indicated that journals have the obligation to define specifically what conflicts of interest are, how to identify them and how to handle them with respect to their editorial teams. Nonetheless, it should be pointed out that, in the majority of the cases, at least in our country, publications have deficiencies: they lack standardised declaration of conflict of interest forms, the time for which a specific relationship can be considered likely to generate conflicts is not established, who should evaluate the declarations and the way to do so are not indicated and whether the declarations will be published in the articles is not specified.[19] There is still a wide margin for improvement in this area.

An important aspect for an integrated approach to COIs is establishing uniform national policies and guidelines that pose and consider these conflicting situations. The public administration and the scientific societies should promote the preparation of a general reference manual that covers the different

conflicts of interest in daily medical practice, in order to improve –using guidelines and protocols– the detection, understanding and prevention (as far as possible) of them.

Two examples of such action are the World Psychiatric Association[20] and the European Psychiatric Association,[5] which have both issued statements about the ethical standards for psychiatric practice. These documents incorporate ethical guidelines about the COIs derived from relationships with the industry and those linked to professionals.[13]

Conclusions

Conflicts of interest create situations in which the professionals' decisions and actions related to a primary interest are unduly influenced and compromised by a secondary interest. In psychiatry, the main primary interests include seeking the wellbeing and health improvement of individuals, safeguarding independence in medical education, and protecting the objectivity and integrity of medical research.

Among secondary interests, economic or ideological motivations, the search for recognition and the desire for career advancement stand out. Consequently, COIs can appear in the multiple functions that physicians have: in patient care, in research or administration, in providing expert opinions or in consultancy for commercial organisations. To provide the best evidence-based clinical practice possible, even the most subtle suspicions of COIs should be controlled by a policy of complete transparency, so as to protect patient interests, strengthen the integrity of the profession and maintain public confidence in psychiatry. Such policies will focus on preparing guidelines that make it possible to identify the factors that might lead to conflicting contexts, that offer an ethical and critical framework to recognise and evaluate such conflicts, that present standardised disclosure guidelines and that provide recommendations for resolving them.

Only by being conscious of the magnitude of COIs, their expansion into many fields and the issues that they involve will the bases for controlling them and ensuring their eradication be established. And as Dr Margaret Chan –the ex-Director-General of the World Health Organization– indicated in the 66th World Health Assembly,[21] conflict of interest statements (regardless of whether the COIs are personal or institutional, economic or non-financial) need to be expanded throughout our scientific and healthcare system widely and quickly, and this practice has to become the norm and not the exception.

Conflicts of interest

The authors indicate that they have no financial or personal relationships that might cause a conflict of interest in relation to this article.

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