

Conflict of Interest— An Issue for Every Psychiatrist

To many psychiatrists' dismay, unresolved conflicts of interest between parts of our profession and the pharmaceutical industry continue to be a focus of concern. It is not our purpose to examine individual allegations; as in most investigations, some have been verified but others have not. Rather, this editorial addresses the context in which serious conflict of interest occurs. The impact of investigations of conflicts of interest extends beyond their targets and potentially affects the credibility of all psychiatrists. Psychiatry is reexamining its standards and ethical boundaries for interactions with the pharmaceutical industry. Our standards should address not only the conduct of high-profile opinion leaders, but also our responsibility as individual physicians to deliver to our patients the highest-quality evidence-based medicine.

Conflicts arise when interests that once seemed congruent begin to diverge. For the pioneers of psychopharmacology, the pharmaceutical companies were invaluable allies. Pharmaceutical companies had the latest information on new drugs such as imipramine, chlorpromazine, and diazepam that offered unprecedented therapeutic efficacy for depression, psychosis, and anxiety. Educational programs, advisory boards, and research grants supported a network of opinion leaders who informed clinicians about how to use these revolutionary new treatments. However, as psychopharmacology has matured, education about biological treatment has often narrowed to carefully orchestrated marketing of specific drugs that may have only marginal advantages over other drugs in the same class. As the differences have become smaller, the amount of money involved in marketing has become greater. Research and educational roles blur into this marketing. There is no clearer example of conflict of interest than the participation of prominent psychiatrists in pharmaceutical company speakers bureaus, which supply academic opinion leaders to deliver company-approved presentations that market their drugs to their clinical colleagues in the guise of medical education.

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Because development of drugs at present relies solely on the pharmaceutical industry, the *American Journal of Psychiatry* publishes industry-supported clinical studies of new drugs, when the reviewers and editors judge that they contribute new information that is important for clinicians to consider and that is not available from any other source. Many APA members with world-leading expertise in psychopharmacology are employed by pharmaceutical companies to develop new drugs, and their papers contain valuable data for our readers. In the review process, our expert reviewers, including dedicated statistical reviewers, endeavor to ensure that the methods, results, and interpretation are accurately and completely described. An independent editorial accompanying the article assesses the findings and their importance for clinical practice, along with realistically appraising their limitations. These clinical research articles are a unique part of the education of psychiatrists about new drugs. They offer readers the opportunity to make their own decisions about the merits and results of a study supporting the use of a new drug, because they can inspect the methods and data for themselves.

Many new drugs have made psychiatric and other medical treatments safer and more acceptable to patients. However, there are also unfortunate examples of prominent com-

panies failing to report important information about drugs that is critical for their safe use. The problem for psychiatry and indeed for all of medicine is how clinicians can obtain unbiased, up-to-date information on newly approved drugs. The interacting system of industry-supported clinical trials, advisory boards, and speakers bureaus not always, but nonetheless too often, has resulted in conflicts of interest that have demeaned both psychiatry and the pharmaceutical industry. Mechanisms exist for academic and clinical consortia and the National Institutes of Health to work jointly with pharmaceutical companies on premarketing drug trials; the National Cancer Institute has used this mechanism for the development of cancer chemotherapeutics. A similar collaborative effort involving industry and nonindustry investigators, sponsored and monitored by the National Institute of Mental Health, the National Institute on Drug Abuse, or the National Institute on Alcohol Abuse and Alcoholism, should be required by the Food and Drug Administration (FDA) for at least one study of any new drug, to restore more openness and credibility to the approval process. The information that is obtained can then be disseminated through articles written by nonindustry investigators with access to all the data and through continuing medical education (CME) efforts that do not involve pharmaceutical company speakers bureaus to dictate what is presented.

The development of better treatments is an urgent need for our patients. Strong academic-industrial collaborations help ensure that pharmaceutical companies develop new treatments guided by the discoveries of academic researchers. There is a danger that conflict of interest concerns may discourage these collaborations, which are crucial if our field is to develop the next generation of treatments based on discoveries in genetics and neurobiology. Thus, psychiatrists who participate in the development of new treatments and in education about their use have special responsibilities to be transparent and circumspect about any conflicts of interest. Academic positions and leadership in our organizations convey similar responsibilities. The American Association of Medical Colleges has adopted a model code of conduct that allows for reasonable reimbursement from pharmaceutical companies for research and educational activities. Most medical schools are now adopting their own versions of this code. The model code leaves to the discretion of each faculty physician the assessment of whether specific activities are truly education and research or whether his or her participation is being unreasonably compensated because it fulfills the marketing aims of the companies. Reliance on self-judgment is risky if personal income is potentially involved. The code of conduct will be more effective when it is coupled with a peer review system, similar to the ethics committees of APA district branches that help enforce ethical standards for clinical practice.

As individual practitioners, we may feel that we are not affected by public concern over these issues, which often focuses on the acts of a few of our colleagues. Congressional hearings and articles in the *New York Times* or *Boston Globe* are far removed from our own practices. But our profession suffers from these episodes and, more important, our patients do as well, because the public and private resources available for the care of our patients depend upon the public perception of the integrity of our profession as a whole. Therefore, each of us has a personal stake and a professional role in the conflict of interest issue. Most of us may never receive a check from a pharmaceutical company. However, by allowing companies to pay for and thus dictate our CME, we support the marketing context in which these acts occur. Our ethical principles as physicians are designed to protect our patients in many ways—*primum non nocere*, confidentiality, prohibitions of boundary violations. We now need to protect our patients from conflicts of interest in the selection of their treatment. The FDA has already taken leadership in limiting gifts and other inducements that historically were part of drug marketing. Guidelines for the type of pharmaceutical industry support that we each accept for our professional activities, including CME, and how our receipt of this support is shared

with our patients when we prescribe drugs need to be more precisely defined by APA and our other professional organizations.

APA ethical guidelines currently take into account the considerable expense of CME and journal publication and therefore allow pharmaceutical company support for these activities. Advertising in the *American Journal of Psychiatry* is separated from editorial functions by a strict fire-wall to assure that it does not influence editorial decisions or intrude into our medical content, but display advertisements seem increasingly incongruous with our standards for unbiased medical information. Pharmaceutical companies themselves are decreasing these advertisements, because they do not meet all their marketing needs, and instead are increasing direct-to-consumer advertisements. Industry-supported CME symposia at the APA annual meeting and other professional and academic settings are also carefully regulated, but many presentations are closely related to their sponsors' products, and the enticement of food is often added. It is timely to reexamine and revise these practices.

More acceptable alternatives—industry support of education through unrestricted gifts to APA, universities, or other public institutions and journal advertising that resembles sponsorships on public television rather than network prime time commercials—will likely result in less financial support than we currently receive for our professional activities, because this financial support would no longer be assumed by the companies as part of their marketing strategy. The subsidy that each of us has been receiving is part of what has fueled the excesses that are currently under investigation. Accordingly, in the future it may cost more to attend meetings, to earn CME credits, and to receive journals. Pharmaceutical companies may continue to hire their own speakers and to offer subsidized CME and publications to clinicians through their marketing divisions and private medical education companies. Each of us must acknowledge—in the choices that we make—our own responsibility to limit conflicts of interest in order to preserve the integrity of the field that is so important to us all.

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