

Editorial

Non-financial conflicts of interests
in psychiatric research and practice

Mario Maj

**Summary**

Not all conflicts of interests affecting psychiatry are financial in nature. Our field is vulnerable to some varieties of non-financial conflicts of interests. Examples include the possible conflict between a researcher's allegiance to a school of thought and the integrity of psychotherapy research, or

between a psychiatrist's political commitment and patients' welfare.

Declaration of interest

None.

Mario Maj (pictured) is Professor of Psychiatry and Chairman at the Department of Psychiatry, Naples University. He is President-Elect of the World Psychiatric Association and has been President of the European Psychiatric Association and the Italian Psychiatric Association. He has been active as a researcher and an educator on behalf of the World Health Organization in Africa, South-East Asia and Latin America. According to the Institute of Scientific Information, he is the Italian psychiatrist having been cited the most in the period 1981–2005.

Conflicts of interests occur when doctors are unduly influenced by a secondary interest (i.e. a personal incentive) in their acts concerning one of the primary interests to which they are professionally committed. These primary interests are: the welfare of their patients, the progress of science (if they are researchers), and the education of their students, residents or colleagues (if they are scholars). The secondary interests that may unduly influence doctors' actions include: financial gain for themselves or for an institution; personal recognition, career advancement or visibility in the media; bestowing favour on a relative, friend or colleague; the allegiance to a school of thought; and political commitment.^{1,2}

Of the conflicts of interests that may occur in medical (and psychiatric) research and practice, one specific variety has predominantly attracted the attention of the scientific and general press: financial conflicts of interests arising from relationships between physicians and drug companies. There is growing empirical evidence of the significant impact these conflicts have on psychiatric research and practice.^{3–5} The suspicion is warranted that current research evidence in the field of psychopharmacotherapy is, to some extent, biased due to the impact of these conflicts, and that clinical practice is consequently misdirected.

However, not all financial conflicts of interests affecting psychiatric research and practice arise from psychiatrists' relationships with the pharmaceutical industry.^{6,7}

In research, the same overt or subtle influence that has been described on the design, conduct, analysis of data and reporting of results of trials supported by drug companies may be also at work in trials funded by public agencies with an interest in promoting the use of the cheapest medications. This may occur especially if the publication of results in line with the sponsor's interest is likely to improve a researcher's chance of future funding. Some trials comparing new-generation with old-generation drugs may have been affected by this kind of conflict.

In clinical practice, doctors, including psychiatrists, are now increasingly pressured by their hospital administrations to be 'productive' (i.e. to see as many patients as possible in their working time) and to use the least expensive treatments. This 'productivity' and use of the cheapest interventions is often not

in the best interests of patients. If a financial incentive is involved, a conflict of interests may occur.

In addition, not all conflicts of interests affecting research and practice are financial in nature. Our profession is particularly vulnerable to some forms of non-financial conflicts of interests which deserve some discussion.

The 'allegiance effect' in psychotherapy research

An example of a non-financial conflict of interests affecting psychiatric research is given by the possible conflict between the secondary interest represented by the researcher's allegiance to a given school of thought and the primary interest represented by the progress of science.

The impact of this 'allegiance effect' on the outcome of psychotherapy research has been repeatedly described. A systematic review⁸ found that the combination of three measures of researcher's allegiance accounted for 69% of the effect size of treatment outcome in studies comparing three psychotherapeutic techniques. Interestingly, some mechanisms by which the researcher's allegiance may operate are very similar to those explaining the impact of financial conflicts of interests on the outcome of drug trials: selection of a less effective intervention to compare with the researcher's favoured treatment; unskilful use of the comparison treatment; focusing on data favouring the preferred treatment in study reports; and failure to publish negative data.

Along with the fact that the proponents of some specific psychotherapies may, for various reasons, be less interested in the scientific validation of their techniques, this allegiance effect may bias the evidence concerning the relative efficacy of the various psychotherapies – exactly like the impact of financial conflicts of interests may bias the evidence concerning the relative efficacy of the various psychotropic drugs. Not surprisingly, it has been argued that 'the balance of investigator allegiance across the schizophrenia literature is against psychodynamic or supportive methods and in favour of cognitive-behavioural therapy approaches'.⁹

Psychotherapy research may also be affected by financial conflicts of interests; for instance, if the researcher who focuses on data favouring a given treatment in study reports or who fails to publish negative data is the owner of a private school of psychotherapy.

**Psychiatrists' political commitment
and patients' welfare**

An example of a non-financial conflict of interests affecting psychiatric practice is given by the possible conflict between the

secondary interest represented by a psychiatrist's political commitment and the primary interest represented by patients' welfare.

I live and work in a country in which a minister of education stated some years ago that a psychiatrist should always be a political activist. Indeed, being so may be very useful to psychiatrists in fulfilling their professional duties. This applies, in particular, to the practice of community mental healthcare: being a political activist may mean that a psychiatrist has regular contact with several community agencies which may facilitate patients' social inclusion. However, it is a fact that some political credos are often associated with a strong prejudicial attitude against the use of medications in psychiatry and the hospitalisation of psychiatric patients. This attitude may sometimes amount to fanaticism, with the expression of sentiments such as 'those who prescribe psychotropic drugs are like pushers' or 'psychiatry does not need any beds'.

Of course, everybody is free to hold and profess even extreme ideas, and one could argue that these views may sometimes represent a stimulus to the field. However, if a psychiatrist holding such ideas (or, even worse, a psychiatrist wishing to please a senior consultant or a manager holding such ideas) denies pharmacological treatment and/or hospitalisation to a severely depressed patient, who then dies by suicide, is this not a tragic instance of conflict between the secondary interest represented by the psychiatrist's political commitment and the primary interest represented by the patient's welfare?

A prejudicial attitude against the use of medications in psychiatry may more often manifest itself as the stubborn refusal to learn to use them adequately and to even consider reading drug treatment guidelines, because this would mean acknowledging the essential therapeutic role of something which is, instead, regarded as only a marginal ingredient of care. The consequence of this attitude is that medications are used, but in an irrational and chaotic way, again with significant detriment to patients' welfare.

Special interest groups

It has been rightly pointed out¹⁰ that there are now in our field 'special interest groups', consisting of prominent opinion leaders with significant financial conflicts of interests (arising from their relationships to drug companies), who exercise a powerful impact on the field in their various capacities (e.g. as editors or referees of scientific journals, or as contributors to treatment guidelines). One could argue, however, that similar special interest groups may also exist, consisting of prominent leaders with significant non-financial conflicts of interests arising from their strong political commitment. They may exercise an equally powerful impact on our field acting, for instance, as contributors to mental health policy guidelines or consultants to governments. Moreover, when acting as referees for scientific journals or evaluating research projects submitted to public agencies, they may be biased against sponsored drug trials or unfairly favour colleagues who share their political credo.

It is probably useful to mention one more emerging circle, that of 'two-sided' experts, eloquently advocating opposite positions (for instance, being for or against the use of new-generation medications) depending on the context in which they speak

(e.g. a sponsored symposium *v.* a meeting of a governmental task force).

Conclusion

It is beyond the scope of this editorial to list what can be done to address the issue of financial and non-financial conflicts of interests in psychiatric research and practice. One point I would like to make, however, is that awareness of their existence and their impact on our field is a first, necessary step. There is today an acute and welcome awareness of the impact of financial conflicts of interests arising from psychiatrists' relationships with drug companies. The same cannot be said for non-financial conflicts of interests.

Is the fervent allegiance to a given school of thought or an active political militancy, in itself, something bad or inappropriate for a psychiatrist? Certainly not. Is being a consultant to a drug company in itself immoral or unethical? Again, it is not. Both can be useful to psychiatrists in the fulfilment of their professional duties. However, as far as they may collide with the primary interests represented by the patients' welfare and the progress of science, both may be a source of conflicts of interests. It is not uncommon to discover that those people who are very vociferous in denouncing one type of conflict of interests are particularly susceptible to another.

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