

Conflict of interest: The elephant in your practice

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One of the core and essential elements of clinical practice, and in fact for all professional traditions, is the fiduciary relationship, in which the primary interest is to serve solely for the benefit of patients. In our increasingly complicated world a myriad of secondary interests always threaten to subvert our fiduciary obligations. These secondary interests may include financial gain from third parties, a desire for professional advancement or recognition, favours to significant others (such as colleagues or families), and even religious or political demands. When our professional judgement with respect to our primary interest is unduly influenced by our secondary interests there exists a conflict of interest.¹⁻³ This has to be differentiated from the dilemma of 'dual agency' that usually occurs in forensic settings when from the outset the practitioner is faced with conflicting responsibilities or loyalties owed simultaneously to the person being examined and other third parties.^{4,5} Although it is possible that dual agency and conflict of interest issues can overlap, the vital characteristic of a conflict of interest is that the primary interest (i.e. the patient) is mostly unaware of - in this instance - the psychiatrist's secondary interests.

A possible truism is that it is not possible to escape unscathed from conflicts of interest, as their existence is in the nature of modern practice, and there are no guidelines that realistically determine when a given practice is substantively wrong. Other than documenting the prevalence of the frequently unhealthy relationships between pharmaceutical firms, clinicians and academics there is a surprising dearth of empirical data on how often psychiatrists are confronted with potential conflicts of interest and how they manage these situations.^{1,5}

Another truism is that most practitioners are somewhat aware when they may have a conflict of interest, but generally pride themselves on being able to transcend this (by virtue of their supposed intellectual objectivity). This

loftiness is not confined to medical practice. There are instances where a judge adjudicates a case in which his close friend acts as an expert for one of the parties, and fails to appreciate that it is not that he produced the correct judgement, but that he failed to see the problem of an appearance of impropriety. In other words, practitioners have to anticipate that they may have a potential conflict of interest that needs to be managed beforehand. Also, it implies that having a conflict of interest is not always evidence of wrongdoing, but rather a problem of appearing to undermine the trust a community has in their professionalism.

Our relationship with pharmaceutical firms

The egregious behaviour of some pharmaceutical firms, who distorted or suppressed drug trial data with the connivance of prominent researchers, and bribed prominent psychiatrists to promote their products (without disclosing their conflict of interest) has been relentlessly exposed.^{6,7} Some of the miscreants have now been 'rehabilitated', and are back on the lecture circuit (armed no doubt with a slide in their presentations listing all their benefactors). But these are extreme cases, and should not obscure the inescapable fact that we rely on pharmaceutical firms to create and supply the drugs without which psychiatry would indeed be a most primitive discipline. Continuing medical education (CME) activities could generally not occur without industry support, and many practitioners rely on information provided by representatives, which usually is biased favourably towards their products.^{2,8}

Many of us have formed good friendly relationships with these representatives and we accept their trinkets and sponsored trips to conferences. We unfortunately do consider ourselves incorruptible, and never seem to realise that many gifts (including those from patients) are not for what one has done, but for what one is now expected to do. The argument that even small gifts, such as pens and writing pads resplendent with company logos must subtly influence our prescribing habits (otherwise the firms would not shower us with them), has not been proven. Psychiatrists

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are subjected to competing interests, and possibly do not remember which firm gave them the most or best gifts. But in my (unproven) opinion the effect of this largesse has been to convince psychiatrists to use the latest medications in favour of the old ones. There have been some impressive meta-analyses that have confirmed that the first generation neuroleptics (in lower doses) and antidepressants still do compare favourably to the second generation drugs in their efficacy. Here the conflict of interest lies in the reality that the older drugs are cheaper, and in this age of diminishing funding the prescribing psychiatrist often fails to consider their patients' financial limits (often via their medical aid benefits), because the firms have influenced them to prescribe the newer exorbitantly priced drugs. There are no doubt other unrecognised conflicts of interest that arguably are as important.

Admission to hospital and our responsibilities to the community

Hospitals, especially psychiatric clinics, often offer rooms and other facilities at rather reasonable rates to psychiatrists to encourage them to admit patients. A colleague recently described how she felt pampered by the staff at these clinics, which included providing her with food and drink. In my private practice I evaluate patients who apply for disability benefits from their insurance companies on grounds of psychiatric illness. It has been depressing to note how quickly they were hospitalised on their first consultation with a psychiatrist, all too often because the patient complained of stress (often caused by conflict with colleagues at work). They generally remain in hospital until their medical aid funds are exhausted. Conversely my colleagues at Valkenberg Hospital have frequently complained that seriously ill patients are transferred from private clinics likewise when their funds run out, when it was surely obvious ab initio that a lengthy admission would be needed. It seems that there may be a subtle pressure on psychiatrists to admit their patients to ensure that the clinic remains financially viable.

The state sector has its own admission problem. Involuntary admissions are predicated on the criteria that a person with a serious psychiatric disorder (and who is incompetent to make decisions) can be admitted against his will, if he/she is deemed to be a danger to self, others or risks damaging his/her reputation. Many would argue that this is necessary not only because the person then receives much needed care (i.e. satisfying the rule of beneficence) but that the community (usually the family) is protected from harm. It is in the balancing between the perceived interests of the community against the expressed wishes of the patient that these conflicts of interest occur, and is compounded by the failure of all risk assessment tools to predict harm reliably in any specific person.⁵ The legislation is empowering clinicians to make judgements that in many cases are not possible to determine. In addition, the increasingly influential Recovery movement encourages clinicians to prioritise their patients' wishes over the fears of the community.⁹ In this climate, choosing the least harmful option may not be easy.

Drug trials and research

The undue, sometimes corrupt, influence that pharmaceutical firms have used to research, register and promote their products are well known, and do not bear repeating here.^{6,10} We can hope that this will be more strictly monitored in future.

Most drug trials in South Africa are now being conducted in the private sector, where psychiatrists recruit subjects from their own pool of patients. Even though all subjects sign informed consent each surely must expect that her treating-researcher psychiatrist still has her best interests as the priority. Typically subjects get randomly and blindly assigned to be treated either by a placebo, comparator drug or experimental drug. Consequently, a subject, who does have a clinical disorder is either going to receive no treatment, or possibly ineffective treatment with potential adverse effects. What is not disclosed to the patient-as-subject is how big the financial reward her psychiatrist will earn having exposed her to either ineffective or even harmful treatment.

Another interesting conflict of interest arises when a research unit advertises in the media for subjects for recruitment into a study. People who possibly have never been treated present themselves for much needed treatment, and, again, are assigned to treatment groups that may not only be ineffective, but actually harm them. These subjects, although they may have understood the risks of the trial, probably still believed that the psychiatrists had their best interests in mind, not realising that researchers have loyalties to the enterprise of science (which does not always respect the benefits due to individuals), or to their ambitions to publish scientific papers and achieve renown and promotion.¹⁰

The creation of Guidelines

A couple of years ago I was asked to review the draft treatment guidelines for bipolar mood disorder that the South African Society of Psychiatrists (SASOP) was creating. Every drug proposed for first, second and third line treatment was a second or even third generation drug. None of the older drugs were included, despite the now sturdy meta-analysis that confirms haloperidol's (which I remember a colleague declare 'to be poison' at a drug list meeting) superiority for the treatment of acute mania.¹¹ Up to 60% of clinicians who author treatment guidelines have some financial dealings with pharmaceutical firms.⁸ Not uncommonly in many meetings colleagues will provide colourful anecdotes how a particular patient only responded to a particular agent, and then insist that this drug be included in the usual armamentarium. Pharmaceutical firms have legitimate business interests to ensure that their products are included on essential drug lists, but we have to guard against possible divided loyalties between firms and health authorities. The tension here is between providing guidelines appropriate for the conditions in our country versus the cajoling of the representatives of a firm.

Children and adolescents (minors)

Minors do not enjoy full autonomy over their lives, and therefore child psychiatrists are almost automatically cast in the role of a de facto parent or authority figure.⁵ A therapist may find themselves caught between the demands and expectations of the child's parents, schools, or child welfare

agencies. The child may expect the therapist to be their advocate, not fully understanding what may actually be in their best interests. Sometimes forced removal of the child is at issue, or the psychiatrist has to support the parents' wishes that may conflict with the child's desires.

Institutional loyalties and distributive justice

The most obvious example here occurs in consultation-liaison psychiatry, where medical colleagues request an opinion for implementation of their treatment plans. There are always limited resources, which have to be allocated in a just fashion. The psychiatrist will be engaged to assess whether a particular individual qualifies for an organ transplant, or other expensive surgery. Clearly these patients have a primary need for these procedures, but the psychiatrist has also to be loyal to the medical team and the institution that provides the resources.

Another well known situation is that hospitals are bound by essential drug lists that restrict the use of expensive, but sometimes more effective, medications. Again the criteria used to select those patients who may benefit from these drugs delineate between the needs of the institution and those of the patient.

Political and religious affiliations

We live in a multi-ethnic society, in which clinicians and their patients may be devoted to extreme views inimical to each other. The conflict of interest arises when the patient, in revealing his belief systems, has no idea what his psychiatrist's worldview is, and whether this will unduly influence therapy. Most psychiatrists would deny that their personal belief systems influence their practice, which may just be a sign of non-reflection and denial. Certainly therapists who rigidly adhere to certain paradigms, especially those that have little scientific validity, are displaying a hidden conflict that their patients ought to know about.

Recommendations

In 2009 the Institute of Medicine (IOM) issued a set of recommendations which basically required that all institutions, presumably including professional societies, should draw up policies of disclosure and regulation of conflict of interest.^{2,8} The IOM was almost exclusively concerned with financial causes of conflicts of interest, and was equivocal about what constituted a substantive conflict of interest (as they recognised that clinicians, researchers and academics were entitled to some payment for their services). The first important step is that clinicians have to declare their potential conflicts of interest openly, and hope that others are then able

to ascertain whether they have indeed promoted their sponsor's interests.

In many countries in the European Union (EU) pharmaceutical firms are not allowed to give doctors gifts or sponsorship. Firms do contribute to supporting CME and conferences, but under stricter supervision. In my opinion the industry would welcome such regulations here, as they are pressurised to spend lavishly on conferences and sponsorships in order not to be outdone by their competitors, and would still be willing to support bona fide academic activities, albeit in a more subdued dignified fashion.

Given the aforementioned, does this also include an obligation to inform patients what our inherent biases and loyalties are, before commencing treatment? An important first step would be for our professional societies to draw up policy guidelines, with mechanisms by which conflicts of interest can be reported, assessed, and in many cases actually allowed.

In conclusion, our profession should include education about conflicts of interest in CME programmes, issue policies regulating disclosure that are presented to patients and colleagues, and finally set up a mechanism whereby colleagues can be informed or warned about their own practices.

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