

CME 'conflicts of interest'

In his editorial ("Sponsored CME: Do drug companies influence the content?" From the Editor, *CURRENT PSYCHIATRY*, August 2007, p. 17-18), Dr. Henry Nasrallah argues that most CME speakers in psychopharmacology have financial relationships with more than one pharmaceutical company. Consequently Dr. Nasrallah says, "it would be difficult for speakers to assume a conflict of interest." There are several reasons why this assumption is not reassuring.

Sponsor drugs often are compared against placebo, generic medications, or nonpharmacologic interventions, none of which can offer the presenter competing funding. Support from multiple sponsors may create a bias toward the mean, and differences among drugs may be minimized. A speaker might not receive equal support from all sponsors, and therefore one company may have a greater financial relationship with the speaker. Many speakers are supported by several, but not all, companies.

No matter how we rationalize it, when speakers receive pharmaceutical support there will be conflicts of interest. The medical academy must acknowledge this fact and decide if presentations by sponsored speakers merit CME status or if they are too similar to infomercials.

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Dr. Henry Nasrallah is almost convincing in his defense of drug company sponsorship of CME programs.



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However, I believe that closer scrutiny reveals problems with his reasoning.

Dr. Nasrallah advances several arguments for maintaining the status quo. He notes that teaching institutions generally lack funds to cover the costs of CME programs, and existing regulatory CME oversight is sufficient to ensure neutrality. He also contends that CME speakers' financial relationships with multiple, competing pharmaceutical companies help prevent "a conflict of interest."

Many nonmedical professionals must engage in ongoing education, and they manage to fulfill these mandates without funding from the pharmaceutical industry. The nature of CME would change without corporate sponsorship. Indeed, Dr. Nasrallah lists "refreshments and meals" as costs associated with sponsoring CME, but we don't need free food to learn. Perhaps we should pay for our own meals for the sake of neutrality.

With regard to Dr. Nasrallah's contention that speakers' multiple financial relationships help prevent bias, I feel that his argument exposes one of

the greatest sources of bias, that "most CME speakers are experts in psychopharmacology." The concern isn't that speakers will favor one drug over another, rather that they will overstate medications' efficacy in general, downplay side effects, and give short shrift to nonpharmacologic interventions.

Robert Hierholzer, MD
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In his editorial, Dr. Nasrallah discusses the relationship between drug companies and CME forums and imagines that science—not special interests—best determines physicians' prescribing choices. The issue is not whether a speaker participating at a drug company sponsored CME event endorses a medication but, more fundamentally, the codependent relationship between the pharmaceutical industry and the medical establishment.

Physicians and patients are the offspring of this codependent relationship and often assume that the only response to illness or disease is prescribing one or more drugs. Advertising's ubiquity fuels this belief thoroughly and subtly, similar to how parents bequeath their values and communication style to their children. Advertising has become so pervasive in all areas of professional and consumer life that it blares non-stop from the background.

The choice of Seroquel vs Geodon or Lexapro vs Effexor XR increasingly becomes our only choice in a society of ever-deepening disintegration and desperation, in which the easy and quick becomes the unquestioned norm and psychiatrist-diagnosed mental illness is more common.

continued on page 19

continued from page 14

If psychiatrists don't work to expose the way the marriage between medicine and the pharmaceutical industry influences our clinical decisions as well as our thought processes, physicians and patients simply perpetuate the same unquestioned codependency inherited from our mega-industry parents. This dysfunctional system consumes more of our choices until it alone determines our decisions. While doctors, the pharmaceutical industry, and insurers get richer—priding ourselves on our good work—society grows more impoverished and seeks solutions to expanding malaise from the system that needs illness to continue making profits.

P.S. The first draft of this letter was written with a pen commissioned by AstraZeneca on a note pad paid for by Eli Lilly.

Jeff Berger, MD
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Dr. Nasrallah Responds

Despite the perceptions of a "collusion" between the continuing medical education establishment and pharmaceutical sponsors, the fact is that CME audiences are sophisticated enough not to tolerate biased presentations. Further, CME providers are adhering ever so strictly to both the letter and the spirit of the CME guidelines. Potential conflict of interest is being more vigorously disclosed, addressed, and resolved by CME accreditation planners and by speakers themselves.

The CME process has seen unprecedented improvements over the past 2 years, but old perceptions of "scratching the sponsor's back"—which admittedly occurred in the past—persist. Thus, practitioners must actively participate in providing feedback about CME offerings regarding the extremes: blatant bias or exemplary, evidenced-based neutrality.

Finally, although psychopharmacologic advances represent a large proportion of the new knowledge in psychiatry, it is my hope that pharmaceutical companies would support CME programs that update practitioners about progress in psychosocial interventions as well.

Henry A. Nasrallah, MD
Editor-in-Chief

Opiates calm addicts' anger

I have treated several opiate addicts whose family members have reported them as being "angry" without opiates ("A life of drugs and 'downtime,'" Cases That Test Your Skills, CURRENT PSYCHIATRY, August 2007, p. 98-103). When these individuals are asked if they feel angry without opiates, their response has been "yes, how did you know?"

These patients also said they used opiates not to get high but to avoid being angry and impossible to be around. In these select few—who also had not responded to antidepressants or mood stabilizers—I have found thiothixene to be especially helpful to rapidly reduce anger. None of these patients were psychotic, and all had good work histories.

I recall a patient who was suicidal because she couldn't stand how angry she was without opiates but knew that staying on the drugs wasn't an acceptable option.

Sheridan Tucker, MD
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Treat the head and the heart

Dr. Henry Nasrallah's editorial on mortality in schizophrenia ("Dying too young: Cardiovascular neglect of the mentally ill," From the Editor, CURRENT PSYCHIATRY, January 2007,

p. 15-16) to my knowledge could be the first article on the subject written by a psychiatrist. It is time that psychiatrists remember that the specialty is a branch of medicine and its practitioners are physicians.

Because of psychiatry's unique understanding of the effects of the mind and emotions on the body—particularly on the heart—we have an opportunity to make a major contribution to medicine in terms of understanding and treating heart disease, the world's leading cause of death.

I practiced family medicine for many years and later devoted my career to adult and child psychiatry. I employ an integrative approach to psychiatric illness because of my background in medicine and psychoanalysis. I focus on the physiology of mood and its link to the development of heart disease and diabetes.

Based on the literature, the causes of premature death in schizophrenia—such as heart disease and diabetes—result from disturbances in underlying physiology including activation of the hypothalamic-pituitary-adrenal axis and sympathetic adrenal-medullary system, autonomic dysfunction, low heart rate variability, and platelet activation. These are the same physiologic aberrations that increase the risk of depression in patients with heart disease.

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Correction

An illustration of the heart was mislabeled in "Managing anxiety in patients with implantable cardiac defibrillators" (CURRENT PSYCHIATRY, September 2007, p. 19). The error has been corrected in the article at CurrentPsychiatry.com.